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Executive Summary

South Dakota is predominantly a frontier State with a population of 754,844 people spread over 66 counties and 75,885 square miles. Vast land areas and relatively few people characterize the State. Of the State's 66 counties, thirty-five are classified as frontier (less than 6 persons per square mile) while 30 are considered rural (6 to 99 persons per square mile). Only one county is classified as urban (100 or more persons per square mile). Population density varies tremendously from one locale to another. The majority of the State's population is located in the eastern one-third of the State, with a population center in Minnehaha County, site of Sioux Falls, the State's largest city. A second population center anchors the western side of the State, in Pennington County, which is the site of Rapid City, the State's second largest city.

As the State Mental Health Authority, the Division of Mental Health (DMH), under the auspices of the South Dakota Department of Human Services (DHS) is responsible for the administration of a comprehensive, community-based mental health delivery system. Central to South Dakota's community-based mental health delivery network is eleven private, non-profit community mental health centers (CMHCs). Each is designated catchment areas to insure services are provided to all of the state's 66 counties. These centers have demonstrated a commitment to providing quality services. These providers have a keen awareness of, and an uncanny ability to overcome a number of environmental barriers, including those created by the State's cultural and socioeconomic composition.

Through strategic planning, the Division of Mental Health and the Mental Health Planning and Coordination Advisory Council have identified needs and priorities for the community mental health system for the next three years. To begin this process a vision statement was created – "South Dakota will promote prevention and recovery through an integrated mental health system that provides access to a continuum of services and supports that allow full participation in the community." The President's New Freedom Commission on Mental Health's final report drove the process of planning for ways to improve the system of care for individuals with mental illness. The goals identified as priority areas include the following:

- Goal 2: Mental Health Care is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
  - 4.1 Promote the mental health of young children.
  - 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Cultural competency will be addressed within each of the goals.

Federal Funding Agreements, Certifications and Assurances

Public Comments on the State Plan

In order to provide opportunities for the public to comment on the State Plan, the Division of Mental Health began the process of developing the plan during the April Advisory Council meeting when a vision statement was developed and priorities were identified. During the June meeting, the council worked on specific goals and tasks related to each of the priority areas and timelines for achieving such goals/tasks. Once a draft of the State Plan was created, copies were distributed to Advisory Council members prior to the August meeting. A public notice was also placed in several South Dakota newspapers notifying the public of the draft and requesting feedback and/or participation in the August council meeting. Comments were also solicited from the Council of Mental Health Centers and each community mental health center.

Set-Aside for Children's Mental Health Services Report

Maintenance of Effort Report (MOE)

State Mental Health Planning Council Membership Requirements

Establishing an organized system of care requires a planning process that involves representation from consumers and families using the services, mental health service providers, and other related agencies and services. The Mental Health Planning and Coordination Advisory Council was previously comprised of a statutorily defined membership. During the 2002 legislative session, however, the membership requirements were taken out of State statute and added to the Advisory Council by-laws. This change will allow for a simpler and smoother process for updating membership composition as the federal requirements change, as it will not require state legislative action.

The Mental Health Planning and Advisory Council is comprised of three family members of children with SED. This ratio of parents of children with SED to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council. In addition, one of the primary consumers of mental health services is an adolescent at least 15 years of age and under 18 years of age. As stipulated by law not less than 50% of the members of the Council are individuals who are not State employees or providers of mental health services. See Attachment 8, Mental Health Planning and Coordination Advisory Council By-laws, for council specific membership requirements.

State Mental Health Planning Council Membership List and Composition (Table 1)

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
Kim Malsam-Rysdon	State Employee	Director, Division of Mental Health	E. Hwy 34 % 500 E. Capitol Pierre, SD 57501 Fax: 605-773-7076
Michelle Powers	State Employee	Director, Office of Special Education	700 Governors Dr. Pierre, SD 57501
Grady Kickel	State Employee	Director, Division of Rehabilitation Services	E. Hwy 34 % 500 E. Capitol Pierre, SD 57501 Fax: 605-773-5483
D. J. Hanson	State Employee	Unified Judicial System	500 E. Capitol Pierre, SD 57501
Darlys Baum	State Employee	SD Housing Development Authority	221 South Central Pierre, SD 57501
James Ellenbecker	State Employee	Dept. of Social Services/State Medicaid Agency	700 Governors Dr. Pierre, SD 57501
Dr. Mark Garry	Provider	Indian Health Services	Sioux San Hospital 3200 Canyon Lake Drive Rapid City, SD 57702
Cory Nelson	State Employee	Administrator, SD Human Services Center	PO Box 7600 Yankton, SD 57078 Fax: 668-3406
Lynn Amdahl	Provider	QMHP providing direct services to adults with SPMI	PO Box 1030 Watertown, SD 57201
Terry Dosch	Provider	Director, SD Council of Mental Health Centers	PO Box 532 Pierre, SD 57501 Fax: 605-224-0123
Tim Reisch	State Employee	Secretary, Dept. of Corrections	3200 E. Hwy 34 % 500 E. Capitol Pierre, SD 57501
Roy Conrad	Provider	QMHP of CMHC providing direct services to children with SED	2000 S. Summit Sioux Falls, SD 57105

S. Ramona White Plume	Family representative of a child with SED	NA	PO Box 325 Porcupine, SD 57772
Cindy Klein	Family representative of a child with SED	NA	1906 Barbara Ave. Sturgis, SD 57785
Amanda Lautenschlager	Family representative of a child with SED	NA	1523 S. Lincoln St. Aberdeen, SD 57401
Cathy Assid	Family representative of an adult with severe mental illness	NA	1709 Gary Drive Sioux Falls, SD 57103
Lois Bates	Other (Not a provider or state employee)	Representative of a statewide family support and advocacy group	422 5th Ave. E Sisseton, SD 57262
Emily Haney-Carron	A primary consumer of mental health services, with preference for an adolescent at least 15 years of age and under 18 years of age at time of appointment	NA	306 E. 10th Ave Milbank, SD 57252
Mark Arneson	Primary consumer of mental health services	NA	2410 Yorkshire Dr. #224 Brookings, SD 57006
Brenda Traver	Primary consumer of mental health services	NA	375 Dakota Ave. South; Apt. 507 Huron, SD 57358
Marley Prunty-Lara	Primary consumer of mental health services	NA	2105 E. Edgewood Road Sioux Falls, SD 57103
Tim Loftesness	Family representative of an adult with severe mental illness	NA	7300 W. Lancaster Sioux Falls, SD 57106
Eileen White	Other (Not a provider or state employee)	Representative of a statewide mental health consumer organization	167 Old Stone Rd. Sturgis, SD 57784

Robert Kean	Other (Not a provider or state employee)	Director, South Dakota Advocacy Services	221 South Central Pierre, SD 57501 Fax: 605-224-5125
Dorothy Schumacher	Other (Not a provider or state employee)	A public educator or administrator	628 5th Ave. Brookings, SD 57006
Martha VanLaecken	Family representative of an adult (62 years of age or older) with severe mental illness	NA	422 W. 4th Ave. Mitchell, SD 57301

Planning Council Composition by Type of Member (Table 2)

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	**26**	
Consumers/Survivors/Ex-patients (C/S/X)	**4**	
Family Members of Children with SED	**3**	
Family Members of Adults with SMI	**3**	
Vacancies (C/S/X & family members)	**0**	
Other (not state employees or providers)	**4**	
TOTAL C/S/X & Family Members & Others	**14**	**54%**
State Employees	**8**	
Providers	**4**	
Vacancies	**0**	
TOTAL State Employees & Providers	**12**	**46%**

Planning Council Charge

The Mental Health Planning and Coordination Advisory Council members are appointed by the Governor of South Dakota as defined in SDCL 27A-3-1.1. The Advisory Council meets quarterly and serves to advise the Department of Human Services and the Division of Mental Health on the preparation of the State and Federal mental health plans, on policy matters related to allocation of State and Federal funds, and on the coordination of planning and service delivery efforts as defined in SDCL 27A-3-1.3-5. See Attachment 8 and 9 for specific functions of the Advisory Council, as well as the policies and procedures for the selection of council members, their terms, and the conduct of meetings.

In addition to the quarterly meeting of the full Advisory Council, subcommittees meet prior to the full meeting to allow for more detailed discussions and input. In 2003, the Mental Health Planning and Coordination Advisory Council made the decision to incorporate the Mickelson Center for the Neurosciences (MCN) subcommittee, which represents the Human Services Center, into the adult and children's subcommittees. The goal of this change is to better foster a "system of care" approach to services, as the topics generated through the MCN subcommittee are relevant to adult and/or children's services and the respective subcommittees. The administrator of the Human Services Center is also an advisory council member and provides a full report on the Human Services Center to the entire advisory council at quarterly meetings.

State Mental Health Planning Council Comments and Recommendations (insert letter from Jim Hagel)

Section I: Description of State Service System

The Department of Human Services
As the State Mental Health Authority, the Division of Mental Health (DMH), under the auspices of the South Dakota Department of Human Services (DHS) is responsible for the administration of a comprehensive, community-based mental health delivery system. The Department of Human Services includes the following divisions, Alcohol and Drug Abuse; Developmental Disabilities; Rehabilitation Services, Service to the Blind and Visually Impaired; Mental Health; as well as the South Dakota Developmental Center and the Human Services Center.

The Division of Mental Health
The Division of Mental Health provides a range of services through purchase of service agreements with eleven private, non-profit community mental health centers (CMHCs). The principle responsibilities of the Division of Mental Health are to establish policy, to develop and administer the implementation of the Community Mental Health Services block grant, to determine and establish reasonable standards and requirements for the locally operated community mental health centers, and to enter into purchase of services agreements for the purpose of assisting in the operation and programs of the local mental health centers. The Division of Mental Health also has the responsibility for the delivery of mental health services within the State's adult and juvenile correctional facilities. In addition, the Division of Mental Health assumed responsibility for a state-operated program of assertive community treatment, known as IMPACT-Yankton (Individualized and Mobile Program of Assertive Community Treatment) as of July 1, 2003. Previously, this program was operated through the Human Services Center, the state psychiatric hospital. IMPACT-Yankton is a state and federally funded program that provides intensive services to individuals with excessive histories of hospitalizations who need very intense services to remain in the community.

In carrying out these responsibilities, the Division of Mental Health staff consists of a full-time director; a program manager for community mental health services who oversees four program specialists, an IMPACT program manager, ten IMPACT mental health professionals, and one IMPACT secretary; a program manager for correctional mental health services who oversees a contract psychiatrist, thirteen mental health professionals and one secretary in the adult correctional facilities; an additional program specialist and two mental health professionals for the juvenile correctional facilities, and a secretary (Attachment 1).

The Human Services Center
The Human Services Center, located in the southeastern tip of South Dakota, is a state-of-the-art, licensed hospital, providing inpatient psychiatric treatment services, and chemical dependency treatment services. The administration of the Human Services Center is under the Secretariat, rather than the Division of Mental Health (the state mental health authority).

Inpatient psychiatric treatment services. Acute Psychiatric Services has a total bed capacity of 60. This area is Medicare approved by the Center for Medicare and Medicaid Services. Acute Psychiatric Services provides for initial assessment of patients and develops and initiates treatment and discharge plans. Acute Psychiatric Services, like all HSC treatment programs, promotes and facilitates independent functioning in daily activities and provides care, treatment and rehabilitation services that will enable the patient to return to and function in the community at the earliest possible time.

The Psychiatric Rehabilitation Program provides services for adult patients who are coping with persistent mental illness and who need to remain at the hospital for longer periods of time. The goal of the program is to assist the patients in developing skills that will help them to live in the least restrictive setting possible. The psychiatric rehabilitation program is made up of 61 beds.

The Adolescent Acute Psychiatric Program provides adolescents, ages 12 through 17, with inpatient psychiatric evaluation and treatment. The goal of the program is to develop and initiate individualized treatment and discharge plans, provide effective treatment, and to support the patient in transition to home or another appropriate placement setting. This program contains 15 beds. Adolescents from this program attend an accredited Alternative School operated by HSC. An intermediate adolescent psychiatric unit is also available. This unit provides additional support and a slightly longer stay than the acute unit. This unit consists of 20 beds and serves adolescents ages 12 through 17.

Long-Term Adolescent Treatment Program provides long-term psychiatric care for adolescents from 12 to 17 years of age. This program contains 12 beds. The goal of the program is to provide comprehensive diagnostic services in order to establish long-term treatment goals. The program works to promote and develop good communication skills and to help the adolescents achieve a better understanding of self, family, and peers. Goals are established to provide and enhance the educational, interpersonal, and basic living and socialization sills that will improve the chances for successful adaptation for movement into a less restrictive environment.

Geriatric Psychiatric Services Program provides diagnostic and therapeutic services of a medical and psychiatric nature to persons 65 years of age or older. These services are also available to adults under the age of 65 if found eligible through the Preadmission Screening and Resident Review (PASRR). Services are delivered in such a way as to give the patient maximum opportunity for fulfillment while residing in the least restrictive environment, including return to an appropriate community setting. This Medicare approved program has a bed capacity of 69.

Intensive Treatment Unit (ITU) is a secure psychiatric facility for certain HSC patients and forensic court evaluation treatment cases referred by circuit court. This unit provides a closer observation for patients who pose a high risk for harming themselves or others. ITU is a 15-bed unit that is structurally divided into two distinct areas. One area is designated for care of adolescents, the second area for care of adults.

Chemical Dependency Treatment Services. The Adolescent Chemical Dependency Program is accredited by the Division of Alcohol and Drug Abuse as a 20-bed inpatient alcohol/drug treatment facility. Applicants must be 13-17 years of age and have a dependency diagnosis. The program is 60-120 days in length. Adolescents from this program attend an accredited Alternative School operated by HSC. The Adult Chemical Dependency program (Gateway) is based on the holistic approach of treatment utilizing the Twelve-Step Program of Alcoholics/Narcotics Anonymous. Integration with inpatient psychiatric treatment services has occurred, allowing for drug/alcohol treatment services to be provided to those individuals diagnosed with co-occurring mental health and drug and alcohol treatment disorders. The program is accredited by the Division of Alcohol and Drug Abuse as a 32-bed inpatient program.

Community Mental Health Centers

Integral to South Dakota's community-based mental health delivery system area eleven private, non-profit community mental health centers. Each mental health center is governed by a local board of directors and each center has a specific geographic service area for which it has responsibility (Attachment 2). These centers must meet administrative rules promulgated by the State Division of Mental Health and must include a comprehensive array of services to children with SED and adults with SPMI. Services include:

Children's Serious Emotional Disturbance (SED) Program (Attachment 3):

* Case management
* Individual therapy
* Family education/support/therapy
* Crisis intervention
* Collateral contacts
* Assessment and evaluation
* Psychological evaluation
* Group therapy for children
* Parent/guardian group therapy
* Liaison services

Continuous Assistance, Rehabilitation, and Education (CARE) Program (Attachment 4):

* Case management
* Crisis assessment and intervention
* Liaison services
* Symptom assessment and management
* Medication prescription administration, monitoring, and documentation
* Direct assistance
* Development of psychosocial skills
* A system for communication and planning
* Encouragement for active participation of family and supportive network

Other services available include:

* Individualized and Mobile Programs of Assertive Community Treatment (IMPACT) in Yankton, Rapid City, Sioux Falls, and Huron (Attachment 5)
* Intensive Family Services (Attachment 6)
* Emergency services
* PATH housing funds
* Disaster related crisis counseling
* Residential (room and board) services (Attachment 7)

* Respite care for children and adults

Behavior Management Systems (BMS) in Rapid City serves the western third of South Dakota. The counties included in the BMS catchment area include Bennett, Butte, Custer, Fall River, Harding, Jackson, Lawrence, Meade, Pennington, and Shannon counties. BMS services include an IMPACT (Individualized and Mobile Program of Assertive Community Treatment) program, which is based on the ACT model.

Capital Area Counseling Services, Inc. (CACS) is located in Pierre and serves central South Dakota. The counties that CACS covers are Buffalo, Haakon, Hughes, Hyde, Jones, Lyman, Stanley, and Sully. In addition to community mental health services, the agency is a core service agency for the provision of alcohol and drug abuse services, through the Division of Alcohol and Drug Abuse. CACS also operates a therapeutic foster care program.

Community Counseling Services, Inc., (CCS) is located in east central South Dakota in Huron and covers a six county area, including Beadle, Hand, Jerauld, Lake, Miner, and Moody. CCS serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse. CCS services include an IMPACT Program.

Dakota Counseling Institute (DCI), Mitchell, serves a five county catchment area including Aurora, Brule, Davison, Hanson, and Sanborn counties.

East Central Mental Health/Chemical Dependency Center, Inc. (ECMH/CD) is located in Brookings and serves Brookings County in east central South Dakota. ECMH/CD serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse.

Human Service Agency (HSA) in Watertown, in the east central part of South Dakota, serves a seven county area. These counties include Clark, Codington, Deuel, Grant, Hamlin, Kingsbury, and Roberts. HSA is an umbrella organization providing professional services to children and adults with mental illness, developmental disabilities, and alcohol and substance abuse issues. HSA also operates Serenity Hills, a residential program that serves individuals with co-occurring mental health and chemical dependency issues.

Lewis and Clark Behavioral Health Services (LCBHS) located in Yankton, in the extreme southeast portion of the State, provides services in seven counties including Bon Homme, Charles Mix, Clay, Douglas, Hutchinson, Union, and Yankton. LCBHS serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse.

Northeastern Mental Health Center (NEMHC) in Aberdeen is located in the north central and northeast part of the State. It covers a large 10 county area, including Brown, Campbell, Day, Edmunds, Faulk, Marshall, McPherson, Potter, Spink, and Walworth

counties. They also operate a residential treatment program for children with behavioral problems and a therapeutic foster care program.

Southeastern Behavioral HealthCare (SEBHC) is located in Sioux Falls, in the southeastern part of the State. Counties included in the SEBHC service area are Lincoln, McCook, Minnehaha, and Turner. SEBHC Children's Center also serves children with developmental disabilities. SEBHC services include an IMPACT Program.

Southern Plains Behavioral Health Services (SPBHS) in Winner is located in rural south central South Dakota. It covers the counties of Gregory, Melette, Todd, and Tripp.

Three Rivers Mental Health and Chemical Dependency Center (TRMHCDC) is located in Lemmon, in the northwestern corner of South Dakota. This agency provides services in four counties: Corson, Dewey, Perkins, and Ziebach. TRMHCDC serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse.

All eleven community mental health centers belong to the Council of Mental Health Centers. This organization meets monthly and employs an executive director. The Council, through its committee structure, is involved in systems review and improvement efforts. See Attachment 12 for more detailed information and best practices at community mental health centers.

Through a long-term strategic planning process advisory council members, the Division of Mental Health, and other key stakeholders identified the following areas as needing attention in the FY02-04 State Plan. The following is an update on each priority area and the action taken thus far to address each.

Priority Area:

Services to individuals with co-occurring mental health and substance abuse diagnoses.

Action:

- The Department of Human Services applied for a SAMHSA Co-Occurring Disorders Grant in FY04 and again in FY05. Through this grant, South Dakota intends to address gaps in services for individuals with co-occurring disorders through an interactive process of infrastructure development and implementing SAMHSA capacity building goals of training, screening, and assessment. The Division of Mental Health, in conjunction with the Division of Alcohol and Drug Abuse and the mental health and substance abuse advisory councils, have also discussed methods to begin implementation of priority areas with limited funding. Towards this end, an assessment of provider readiness is being completed with all community mental health and alcohol and drug providers.
- Policy Academy – a team from South Dakota attended the National Policy Academy on Co-Occurring Mental Health and Substance Abuse Disorders in April 2004. During this academy, an action plan for the State was developed that identifies strategies towards building a more integrated system.

Priority Area:
Address the shortage of psychiatric services across the State, especially in the frontier areas.

Action:

- The shortage of psychiatric services across the state, especially in frontier areas, continues to be an area of concern related to the accessibility of services. The provision of psychiatry services through telemedicine is empirically proven, yet underutilized in South Dakota. During FY04, telepsychiatry services continued to be piloted in one area of the state through Block Grant funding. The Division of Mental Health also continued actively advocating for Medicaid reimbursement for telepsychiatry services. In March of 2004, pharmacological management provided by physicians became reimbursable by Medicaid when provided via telemedicine.

Priority Area:
Address the needs of the geriatric population in South and look for ways of improving mental health services provided to the elderly.

Action:

- A workgroup comprised of the Division of Mental Health, the Department of Social Services Division of Adult Services and Aging, the Human Services Center, and other interested parties met to plan for improved services to the growing geriatric population in South Dakota. During FY03, the workgroup assessed the system of mental health services available to the geriatric population, discussed the gaps in the system that could be addressed with information, education, and/or training. The workgroup then developed a "Geriatric Resource Guide" that lists upcoming trainings, conferences, and educational opportunities. The resource guide has been issued to several associations throughout the State and has been included in many of their newsletters. The guide is also available on state agency websites and will be updated as needed.

Priority Area:
Improve discharge planning between HSC and the community-based system.

Action:

- The Division of Mental Health, the Human Services Center, and representatives from the Council of Mental Health Centers formed a Discharge Planning workgroup to streamline discharge planning to ensure that all individuals, once discharged from the hospital, are aware of and have immediate access to mental health services in the community. To date, this group has developed a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented.

Priority Area:

Expand training/education regarding mental health issues for teachers.

Action:

- The Advisory Council has discussed the need for this priority area to be included in any public education activities (see public education priority area for further information).

Priority Area:

Address the shortage of housing opportunities in the State for consumers.

Action:

- Throughout FY04, the Division of Mental Health continued its involvement in the Homeless Consortium. Working with community mental health centers in utilizing PATH funding and encouraging innovative approaches to using PATH programs to address the lack of housing issues has been ongoing as well.

Priority Area:

Develop a public education campaign to bring public awareness of mental health services to the forefront of the overall health care system in South Dakota.

Action:

- The Division of Mental Health has partnered with the South Dakota Coalition for Children on a project to increase public understanding of children's mental health and the efficacy of early screening and treatment. This project will allow for the creation of a multi-faceted, comprehensive public awareness plan that will be created through a collaboration of public and private stakeholders. Such a plan will set the course for ensuring parents, professionals, and children themselves are better able to determine when to seek mental health services and thus prevent the need for more costly treatment options. Funding for an initial planning summit has been obtained. This summit will take place in the fall of 2004 and will bring together key stakeholders to develop a South Dakota-specific multi-year public awareness plan on children's mental health. Specific tasks regarding the public awareness plan will be included in updates to this multi-year State Block Grant application.

Section II: Identification and Analysis of the Service System's Strengths, Needs and Priorities – Adult Mental Health System

Strength and Weaknesses of the Service System

The Division of Mental Health has identified numerous strengths and weaknesses of the community-based mental health system.

Strengths

The Division of Mental Health and the Mental Health Planning and Coordination Advisory Council have worked together in identifying system needs. The Division of Mental Health and the Advisory Council have developed a very close working relationship, recognizing the importance of all stakeholder involvement in strategic planning processes. The Advisory Council is very involved in development of goals and objectives associated with the CMHS Block Grant and provide ongoing feedback to the Division of Mental Health regarding issues related to service delivery within the community-based mental health system.

IMPACT (Individualized and mobile programs of assertive community treatment) has been developed in 4 areas of the state. IMPACT provides a very comprehensive array of services to individuals with severe and persistent mental illness that have a shown the need for highly intensive services. This service allows the Division to move closer to an overall comprehensive community-based mental health service delivery system.

The Division of Mental Health, along with the Division of Alcohol and Drug Abuse, continues to support a residential treatment program for individuals with co-occurring disorders (mental illness and substance abuse). The program is located at the Human Service Agency in Watertown and is called Serenity Hills.

The Division of Mental Health was fortunate to be involved in a Policy Academy on Co-Occurring Disorders offered by SAMHSA. The Division of Mental Health, along with the Division of Alcohol and Drug Abuse, the Department of Human Services, the Governor's office, service providers and consumers are all actively involved in the development of integrated treatment for South Dakotans with co-occurring disorders. With buy-in to these services from so many stakeholders, the Division is optimistic that integrated treatment for individuals will become a reality within a few years.

The Division of Mental Health provides funding for a statewide Indigent Medication Program. The Indigent Medication Program provides temporary funding to assist individuals in purchasing their medications and/or labs when they have no other means to do so.

The community mental health centers and the Division of Mental Health share a close relationship and work together to develop outcome measures and components of service

delivery for individuals with severe and persistent mental illness. This relationship is helping to shape the development of comprehensive mental health services across South Dakota.

The Division of Mental Health, along with the Department of Human Services Legal Council and Eileen White, an individual diagnosed with mental illness provide a quarterly mental health course to law enforcement officers in training for South Dakota. This course gives law enforcement officers a better understanding of mental illness and application of this knowledge when in the field.

Weaknesses

The combination of poverty and remoteness facing rural areas presents additional challenges in the provision of mental health care. A shortage of providers, along with transportation issues, makes access to services difficult. Issues with appropriateness and access to services for individuals in rural areas are always in the foreground during discussions the Division has regarding service delivery.

There is a definite shortage of housing opportunities for consumers within the state. Many communities lack the low income housing options and/or supervised living options for individuals that cannot live independently.

The current caseloads for case managers at community mental health centers are high. Staff turnover at community mental health centers remains a concern due to continuity of care for individuals needing mental health services.

The Division of Mental Health continues to work with issues regarding improvement of mental health services for the growing geriatric population of the State. Areas of focus will need to be around educating nursing home staff on elderly mental health issues and educating physicians on the uses and benefits of new generation medications.

The current community based mental health system is not oriented towards recovery. The Division will need to take the lead in transforming the mental health system from a maintenance system to a more recovery focused system. The Division of Mental Health will also look to the Mental Health Advisory Council and family members/consumers to provide valuable input into the system change process.

Unmet Needs and Critical Gaps

During the last few years, the Division has been looking closely at the management information system (MIS) and its capabilities in reporting data, along with what data was currently being collected and if that data was being used in strategic planning and policy decisions. The Division of Mental Health found that it does not currently have a process in place for analyzing data collected/reported for Block Grant and outcome purposes. The Division has numerous ways to receive data, but we do not have a process to actually analyze data and base policy decisions or strategic analysis on information gathered.

Although there are evidence-based practices within the State, there is no process in place to measure fidelity of these practices. Furthermore, there may be confusion within provider agencies regarding exactly what definitions of evidence-based practices are, whether the current services meet that fidelity, and what is required for a program to maintain fidelity to an evidence based practice.

Accreditations of community mental health centers are currently only administrative in nature. They do not include outcome-driven qualitative data. The Division of Mental Health does not have a way to collect qualitative information, which could give us a better idea of appropriateness and quality of mental health services across the State.

Local provider infrastructure needs are not compatible with State office infrastructure for accurate data recording/reporting. The Division of Mental Health has used the first Data Infrastructure Grant to update the MIS system to reflect the changing reporting needs for CMHS and State requirements. With the new MIS system, the Division must work to ensure that local provider's infrastructure will be compatible with State infrastructure.

The community-based mental health system currently has waiting lists for individuals needing mental health services. Hand in hand with this is the current high caseload for case managers and staff turnover issues. Workforce development is a major concern for the Division of Mental Health, and is consistently an issue that is addressed in discussions with various stakeholder groups, including the Mental Health Planning and Coordination Advisory Council.

Access to services throughout South Dakota is an issue, but especially in the very rural/frontier areas of the state. Some areas served by the community mental health centers encompass great distances. These areas have difficulty attracting qualified professionals, along with having limited financial resources to provide access to mental health services.

Priorities and Plans to Address Unmet Needs

Through strategic planning, the Division of Mental Health and the Mental Health Planning and Coordination Advisory Council have identified needs and priorities for the community mental health system for the next three years. To begin this process a vision statement was created – "South Dakota will promote prevention and recovery through an integrated mental health system that provides access to a continuum of services and supports that allow full participation in the community." The President's New Freedom Commission on Mental Health's final report drove the process of planning for ways to improve the system of care for individuals with mental illness. The goals identified as priority areas include the following:

- Goal 2: Mental Health Care is Consumer and Family Driven
  - 2.3 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

2.4 Involve consumers and families fully in orienting the mental health system toward recovery.

- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
  - 4.2 Promote the mental health of young children.
  - 4.4 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

These Goals and objectives will play an important part in planning and systems change over the entire three years of this State Plan. Cultural competency will be addressed within each of the goals. Please see the section on **"Recent Significant Acheivements" and "The Future"** for a more in-depth discussion of the priority areas identified and specific goals and objectives attached to each area.

Recent Significant Achievements

The Division of Mental Health continues to focus on interagency collaboration, which not only fosters a system of care but also ensures individuals are able to access appropriate services across agencies. Towards this end, the Division of Mental Health is participating in an effort to create a statewide suicide prevention and intervention plan. The suicide prevention stakeholder group began meeting in November 2002 and is comprised of public, private, and legislative members. Legislative support was also shown through the passage of Senate Concurrent Resolution No. 5 during the 2003 Legislative Session. This resolution supports the creation of a South Dakota plan for suicide prevention. It is anticipated that the statewide plan will be finalized prior to the 2004 Legislative Session. The statewide workgroup hopes to have the suicide prevention plan completed by late summer 2004. Next steps for implementation of the plan include: developing a community toolbox to assist communities in developing local prevention and intervention plans.

Education and training provided to the Mental Health Planning and Coordination Advisory Council has been essential in keeping members informed on various topics. During both FY03 and FY04, one of the quarterly council meetings was held in Yankton, SD. This allowed council members to attend the annual Yankton Mental Wellness conference, as well as tour the Human Services Center. The Division of Mental Health and the Mental Health Planning and Coordination Advisory Council will continue over the next three years to keep members informed and hold many discussions on issues such as recovery, outcome measures, planning/policy development based on data, and many other issues that are important in the provision of community mental health services within South Dakota. Other training opportunities in FY03 and FY04 included regular presentations at council meetings. These presentations included:

- Eileen White – "In Our Own Voice: Living with Mental Illness," which provides an example of recovery from severe and persistent mental illness from the perspective of an individual living with mental illness. Eileen also presents this program (along with the Division of Mental Health and the Department of Human Services legal counsel) at quarterly law enforcement training courses. The goal of the mental health

component of the training is to give law enforcement officers a better understanding of mental illness and application of this knowledge when in the field. Along with these activities, the Division of Mental Health has been able to assist in funding for Eileen to carry the "In Our Own Voice" message to numerous community groups, including employers, consumer groups, and other state agencies. This has allowed an additional component to public education that has become very important to continue.

- Dennis Mohatt, an expert consultant to the President's New Freedom Commission on Mental Health on rural issues, presented on the final report of the President's Commission on Mental Health.
- Brenda Freeman provided the council with a cultural competency training presentation, which included key components and promising practices of cultural competence in the delivery of mental health services to American Indians.
- Barry Pillen with the Division of Alcohol and Drug Abuse shared information on the use of methamphetamines in the state.
- Jim Hagel and Dr. Mark Gary discussed services provided by Indian Health Services (IHS) and the history of the Indian Insane Asylum in Canton, SD.
- Roy Conrad gave a presentation on using play therapy with young children.

Additional training provided through the Department of Human Services includes Division of Mental Health and Human Services Center staff presenting at the NAMI-SD annual conference. The Division of Mental Health will continue over the next three years to take part in the NAMI-SD annual conference and bring important discussions forward to these conferences regarding system change, recovery, and outcome-based performance measures.

An important workforce development activity relates to a federal grant the Division of Mental Health was awarded in FY03. This grant will be used to assist in building the emergency response capacity of mental health and alcohol and drug personnel, as well as other first responders in communities. Training in the Critical Incident Stress Management (CISM) model and the development of South Dakotans able to be CISM trainers will be major activities of the grant.

A workgroup comprised of the Division of Mental Health, the Department of Social Services Division of Adult Services and Aging, the Human Services Center, and other interested parties met to plan for improved services to the growing geriatric population in South Dakota. The workgroup developed the "Geriatric Resource Guide" that lists upcoming trainings, conferences and educational opportunities. The recourse guide has been issued to several associations throughout the State and has been included in many of their newsletters. The guide is also available on state agency websites and will be updated as needed.

The Future

Integration of mental health and substance abuse services for individuals with co-occurring disorders has been identified by the Mental Health Planning and Coordination Advisory Council and the Division of Mental Health as a priority area. Towards this end, the Department of Human Services applied for a SAMHSA Co-Occurring Disorders

Grant during FY04 and again in FY05. Through this grant, South Dakota intends to address gaps in services for individuals with co-occurring disorders through an interactive process of infrastructure development and implementing SAMHSA capacity building goals of training, screening, and assessment. The State's plan followed a logical, sequential process of 1) statewide consensus building, 2) infrastructure development, 3) pilot studies, and 4) regional expansion. Multi-agency collaboration and ongoing project evaluation were also core components. The Division of Mental Health, in conjunction with the Division of Alcohol and Drug Abuse and the mental health and substance abuse advisory councils, have also discussed methods to begin implementation of priority areas with limited funding. Towards this end, an assessment of provider readiness is being completed with all community mental health and alcohol and drug providers. This assessment will provide essential information as South Dakota moves forward with the integration of mental heath and substance abuse services. Timelines for goals associated with this project will continue through all three years of the State Plan.

The Division of Mental Health, the Division of Alcohol and Drug Abuse, the Secretary of the Department of Human Services, provider agencies for substance abuse and mental health, the Governor's office and consumers/family members had the opportunity to take part in a SAMHSA-sponsored Policy Academy on Co-Occurring Disorders in 2004. This Policy Academy allowed the State to bring together a group of individuals that can effect change in provision of services to individuals with Co-Occurring substance abuse and mental health diagnoses across the state. An Action Plan was developed (see Attachment 10) to address issues around delivery of services to individuals with Co-Occurring Disorders. The Division of Mental Health will play an important role in developing a strategic plan for comprehensive services for individuals with Co-Occurring Disorders. The Division of Mental Health will look towards developments in this area for this State Plan and future State Plan goals and objectives related to Co-occurring disorders and integrated treatment.

Another part of the effort to begin movement towards integrated mental health and substance abuse dual diagnosis programs is collaboration between the Division of Mental Health and the Division of Alcohol and Drug Abuse to develop a more comprehensive Management Information System (MIS). In 2001, the Division of Mental Health was awarded a Data Infrastructure Grant. This grant was created to assist states in developing infrastructure with the capability of measuring performance outcomes and reporting on the additional basic and developmental measures developed by CMHS. Due to the antiquated nature of the Division of Mental Health's current MIS, reporting capabilities have been limited in the past. The new MIS will be web-based and will allow both divisions to collect the data necessary to measure outcomes in the community-based systems, as well as meet all HIPAA and federal reporting requirements. The development and implementation of the MIS will continue throughout FY05 and FY06.

Implementing person-directed services throughout the Department of Human Services to improve service satisfaction, cost effectiveness, and quality of services is a goal identified by the department. This would be accomplished with input and participation from service recipients and would result in statewide implementation throughout all divisions

within the Department of Human Services. This goal also includes the need for services that are culturally competent and responsive to individual needs. The Division of Mental Health and the Advisory Council recognize the importance of consumer-driven, strength-based, recovery-oriented treatment. Developing an individualized plan of care for every adult with a serious mental illness will assist in moving the system towards recovery and will allow consumers to actively participate in their own treatment and recovery. The involvement of consumers and families in the move to orient the system towards recovery will be crucial, and the Division of Mental Health will work to involve and support consumers in this system transformation. During FY05, the division with input from the Advisory Council will work to enhance the Accreditation Review process to include a focus on individualized planning and recovery. Components that may be added to the reviews include life quality and peer review elements. The addition of a consumer and/or family member on the review team will also be explored along with the possibility of involving consumers/family members in the training of providers. The Advisory Council also discussed the possible benefits of having a consumer/family liaison within the Division of Mental Health so this will be discussed further as well. By FY06, the updated review process will be implemented throughout the community mental health system. During FY06 and FY07, the division will evaluate the process and make changes as needed. A tool that may assist with these plans is the Data Infrastructure Grant on Quality Improvement.

The Division of Mental Health submitted an application to SAMHSA for the Data Infrastructure Grant on Quality Improvement. This grant will allow the Division to build infrastructure between local providers and the State infrastructure systems to more accurately collect/report data for the CMHS Block Grant and URS Table reporting. This grant will also allow the Division to look at building and maintaining fidelity to evidence-based services being provided across the State. The Division of Mental Health use this grant to assist in refining the community mental health center accreditation process to include outcome driven performance indicators and more fully involve consumers and family members in delivery of mental health services Statewide. The Data Infrastructure Grant on Quality Improvement will continue throughout FY05-FY07.

Along with services that are culturally competent and responsive, the Division of Mental Health and the Advisory Council understand the importance of implementing services which are evidence-based. The Division of Mental Health sought to increase the fidelity and sustainability of current Assertive Community Treatment (ACT) programs, known as IMPACT, through a SAMHSA grant for EBPs toolkit implementation, training, and evaluation. Emphasis was placed on cultural issues, particularly for the State's Native American population. South Dakota also planned to focus on how to maximize EBPs in a predominantly rural environment. By focusing on this EBP initially, South Dakota hoped to both enhance ACT services and foster a culture of acceptance for all EBPs. Grant funding was intended to allow participating sites to increase the fidelity to the ACT toolkit, and over time, become "Centers of Excellence" that would sustain on-site fidelity and disseminate EBP standards statewide. Despite not being selected for funding by SAMHSA, the Division of Mental Health is working to identify other methods of funding this initiative as well as components that can be completed with minimal funding. This will be an ongoing goal over the next two years.

SD Health Care Commission was created by the 2003 legislature and charged with gathering data to assess the health status of South Dakotans, identifying health care priorities that address financing, delivery and programming, and developing measurable health outcomes for selected state initiatives for health care. The legislature also directed the commission to recommend health care policy, monitor health care environments, and address the health care needs of South Dakotans. Representation on the commission includes business and employers, consumers, insurers, health care providers, public and community health workers, the Governor's office, former legislators, tribal members, mental health providers, and the Indian Health Service. Mental Health has been identified as a key area and the Division is playing an active role in the Depression subcommittee that has been formed.

Comprehensive NeuroScience, Inc. (CNS), through grant funding from Eli Lilly, will assist South Dakota in a project designed to improve the quality of behavioral health prescribing practices based on best practice guidelines; improve patient adherence to medication plans; and improve the effectiveness of the dollars spent on Medicaid behavioral drugs. The process will include CNS collecting data from the State Medicaid Office to determine how physicians are prescribing behavioral health medications. This data will be analyzed and a steering committee will establish priority areas that will be targets for quality improvement strategies such as a Quality Alert Package to prescribers, educational briefs, normative report cards and peer-to-peer contacts. The Division of Mental Health will be involved in this project during the first two years of this State Plan.

As discussed in the **"Priority Area and Unmet Needs"** section above, the Division of Mental Health worked very closely with the Mental Health Planning and Coordination Advisory Council to develop specific goals and priorities for development of systems of care and a more comprehensive community mental health system statewide. Using the New Freedom Commission final report as a guide, goals specific to the adults with severe and persistent mental illness are:

- Improvement of cultural sensitivity. The Division of Mental Health will work with WICHE and community mental health centers to develop staff training and administrative structure to ensure mental health services are delivered in a culturally sensitive manner. This will be accomplished through training with a consumer/family focus to be incorporated into the clinical practices of every community mental health center. Areas covered may include development of therapeutic communities and issues surrounding stigma.
- Orientation of the adult system to move towards a more consumer-driven model. This goal will involve close work between the Division of Mental Health, community mental health centers and the Advisory Council in development of a system change model and ensuring the model has a consumer/family focus.
- Development of performance measures around outcomes. This goal includes the work the Division will be accomplishing with the current Data Infrastructure Grant and the Data Infrastructure Grant on Quality Improvement. The Division will be working with community mental health centers on refining of the accreditation process to include family/consumer involvement in the process.

This will also include increased data analysis and development of performance measures around the data that will be collected through the new MIS system.

- Using data analysis to incorporate evidence-based practices into individualized planning. This goal will also require systems change; thereby involvement from the Advisory Council and community mental health centers will be vital to the success of this goal. As in all of the goals, consumer/family focus will be a major component.
- Involvement of consumers and families in orienting the mental health system toward recovery. This goal will be accomplished through continued use of the MHSIP surveys—along with more in-depth analysis of results; increasing the public awareness of recovery through conferences, trainings and various stakeholder workgroups that the Division may be involved in; involvement of families/consumers in training of providers on system change from maintenance to recovery; increasing the use of data to include outcome measures and policy development/planning; development of a family member/consumer liaison to help individuals in access to services; and finally, through the community mental health center accreditation process enhancement to include consumer/family involvement and development of performance measures focusing on outcomes of services.
- Screening for co-occurring mental health and substance use disorders and liking with integrated treatment strategies. The Division of Mental Health and the Advisory Council will work together and use the Strategic Plan developed through the Policy Academy to develop integrated treatment with a consumer/family focus. (See Attachment 10 for Strategic Plan)

The Division of Mental Health will also be working closely with the Clinical Management Team in system-change of the community mental health system to a more recovery focused, individualized system of care. The Clinical Management Team is comprised of clinical directors from across the state, with each community mental health center having at least one representative on the Team. This process involves refinement of the accreditation process and development of performance measures around outcomes of services. The Division, Clinical Management Team, the Mental Health Planning and Coordination Advisory Council and consumers/family members will be working towards this goal over the entire three years of this State Plan. Feedback from consumers/family members will be critical in the process of system change to recovery-focused. The Division of Mental Health realizes the above will involve long-term development plans, and plan on working on goals and objectives over the entire three years of the State Plan.

Other areas identified by the Advisory Council include improving cultural sensitivity and public awareness of recovery with staff/provider trainings facilitated by consumers and adding a consumer/family liaison within the Division of Mental Health.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The Division of Mental Health, in conjunction with the Mental Health Planning and Coordination Advisory Council, has the responsibility to establish a system of public mental health services to meet consumers' needs. Through purchase of service agreements with eleven non-profit community mental health centers, the Division of Mental Health provides Continuous Assistance, Rehabilitation, and Education (CARE) Program and Individualized and Mobile Program of Assertive Community Treatment (IMPACT) services to targeted populations (i.e., adults with severe and persistent mental illnesses – SPMI). The agreements with community mental health centers also include the provision of outpatient services to non-targeted populations. In addition, each community mental health center receives a monthly allocation of state general funds to support emergency services based on the population of their respective catchment areas. Limited room and board services are also available for adults with SPMI at select locations (Attachment 11). These residential facilities provide transitional housing opportunities for individuals who are unable to live independently due to their mental illnesses, while the CARE team provides mental health services and supports. Consumers living in their own residence are also provided direct assistance from the CARE team in maintaining their independent living.

The eleven community mental health centers that the Division of Mental Health contracts with have assigned catchment areas, broken out by county, for which they are responsible. (See Attachment 12)

The CARE Program (Attachment 4) is a comprehensive program for providing treatment, rehabilitation, and support services to identified consumers with SPMI, with the goal of helping individuals live successfully in the community. A CARE team is organized as a mobile group of mental health professionals who merge clinical, medical, and rehabilitation staff expertise within one service delivery team, which is supervised by a clinical supervisor. Services stress integration in normal community settings and are responsive to cultural differences and special needs. Outreach to consumers and the provision of services according to individual needs are the team's highest priority, with the majority of clinical contacts occurring in settings outside of an office setting. The CARE team assumes responsibility for performing case management duties, which include:

1). maintaining current assessments and evaluations;
2). participating in the treatment planning process;
3). monitoring consumer progress;
4). assisting in locating, coordinating and monitoring medical, social, vocational, and psychiatric services as needed (including dental services);
5). developing a plan to manage consumer's financial resources, including payee services as needed;
6). when appropriate, locating and maintaining suitable living environments, emergency services, and other activities necessary to maintaining psychiatric stability in a community-based setting; and
7). providing the following services:

a). crisis assessment and intervention;
b). liaison services
c). symptom assessment and management;
d). medication prescription administration, monitoring, and documentation;
e). direct assistance;
f). development of psychosocial skills;
g). encouragement for active participation of family and supportive social network; and
h). a system for communication and planning.

The IMPACT Program is a comprehensive program for providing medically related treatment, rehabilitative, and support services to eligible consumers through a self-contained program of clinicians grouped together as a continuous treatment team under the supervision of a clinical supervisor. These services are provided regardless of location or frequency to assist the consumer with SPMI cope with the symptoms of their illness, minimize the effects of their illness, or maximize their capacity for independent living and minimize periods of psychiatric hospital treatment. The IMPACT Program is based on the Assertive Community Treatment (ACT) model and is intended to serve consumers who have historically failed in community settings and who have had frequent hospitalizations. IMPACT Programs are required to provide the same services as the CARE Program; however, services may not exceed a ration of at least one primary therapist for every 12 consumers served. An average of 16 contacts per month or more if clinically appropriate must be provided to consumers. See Attachment 5 for a more detailed description of the IMPACT program.

To assist consumers with their vocational goals, community mental health centers coordinate services with vocational rehabilitative services as needed. Several community mental health centers have vocational counselors located within their agencies, which allows for better coordinated services. The Division of Rehabilitation Services is funding a program called “Employment Skills Program”. This is a paid work experience program for individuals diagnosed with mental illness to obtain employment skills in the community. It is a temporary placement of up to 250 hours at a job site. The Division of Rehabilitation Services (DRS) is paying the wages, FICA and Worker’s compensation. DRS is also purchasing the services from community mental health centers to provide job development and job supports at the employment placement. The placement and services need to be coordinated with the community mental health centers to assure the success of the work experience. The Employment Skills Program will provide the individual the opportunity to try various employment occupations, develop work skills and stamina. It is hopeful that the participant will then become employed in the setting that most interests them.

During FY03, the Division of Mental Health and the Division of Rehabilitation Services sponsored technical assistance training on disability benefit determinations for individuals with psychiatric disabilities. This training was provided to assist community mental health center staff in understanding SSI and SSDI benefits so they are better prepared in supporting individuals with mental illness in pursuing careers. Additional

trainings for provider staff and individuals with disabilities have continued throughout FY04.

An important training component of the community mental health system is the Division of Mental Health requirement that all CARE and IMPACT team staff to complete a medication administration-training course and demonstrate the required level of proficiency in accordance with the standards of the Board of Nursing. To assist community mental health centers with this process, the Division of Mental Health and community mental health center staff worked to update the Medication Training Manual, which was created in 1993. The SD Board of Nursing has reviewed the updated manual to ensure it meets their standards.

Because of the need for integrated mental health and chemical dependency services, the Division of Mental Health and the Division of Alcohol and Drug Abuse have a cooperative agreement regarding a residential program to treat individuals with co-occurring disorders through one community mental health center. The Serenity Hills Program is a custodial care facility for adults who are diagnosed with both mental health and substance abuse disorders. It uses a multidisciplinary "integrated" model that combines both mental health and substance abuse treatment within a single, unified, and comprehensive custodial care program. The Serenity Hills Program places an emphasis on the chronic disease model of chemical dependency. This model includes abstinence, acceptance of the chronic incurable nature of chemical dependency, and utilization of self-help groups for support and maintenance. It also includes psychological interventions targeting psychological conditions and chemical dependency issues, especially those that are likely to precipitate relapse or perpetuate the addictive process, which interfere with the client's ability to function independently. See Attachment 7 for more information on Serenity Hills.

The implementation of a comprehensive, organized, community-based system of services is a key strategy in reducing psychiatric hospitalizations within the State of South Dakota. The Division of Mental Health and the Human Services Center, the State psychiatric hospital, are collaborating to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup comprised of individuals from the Division of Mental Health, the Human Services Center, and the community mental health center system was created to work on streamlining the discharge planning process to ensure that all individuals, once discharged from the State hospital, are aware of and have immediate access to mental health services in the community. To date, the group has developed a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented. This group will continue to meet to address any further areas of concern regarding discharge planning.

The Division of Mental Health understands the importance of individuals being able to obtain psychotropic medications when they are being discharged from the Human Services Center and while they are receiving (or waiting to receive) community mental

health services. For this reason, the Division of Mental Health continues to support the Indigent Medication Program, which provides temporary funding to assist individuals in purchasing their medications when they have no other means to do so. During FY02, the Division of Mental Health also purchased subscriptions to the Indicare system for community mental health centers. Indicare is an internet-based system that is used to complete applications to pharmaceutical company programs on behalf of individuals who need such assistance. This system makes accessing pharmaceutical company programs less burdensome, which will allow more individuals to receive such assistance in obtaining their medications. The addition of Indicare, as well as the emphasis on ensuring the Indigent Medication Program is being used as a temporary means of obtaining medications has resulted in 641 individuals receiving assistance during FY04. This is an increase in 227 individuals from FY03. In addition to serving a larger number of individuals in FY04, the waiting list for individuals needing this service has been maintained at zero since FY03. During FY04, the Indigent Medication Program will continue to provide temporary assistance in obtaining medications for those individuals being discharged from the Human Services Center and/or receiving (or waiting to receive) services from a community mental health centers, as well as those individuals being discharged from the corrections system. The Division of Mental Health is also assisting with discharge planning through the correctional system by identifying a staff person in the adult correctional mental health system that will be responsible for setting up community mental health appointments for those inmates with mental illness who have been paroled.

The shortage of psychiatric services across the state, especially in frontier areas, continues to be an area of concern related to the accessibility of services. The provision of psychiatric services through telemedicine is empirically proven, yet underutilized in South Dakota. During FY04, telepsychiatry services continued to be piloted in one area of the state through Block Grant funding. The Division of Mental Health also continued to actively advocate for Medicaid reimbursement for telepsychiatry services. In March of 2004, pharmacological management provided by physicians became reimbursable by Medicaid when provided via telemedicine.

Criterion 2: Mental Health System Data Epidemiology

The Division of Mental Health provides mental health services to individuals who meet the following severe and persistent mental illness eligibility criteria:

1. The consumer's severe and persistent emotional, behavioral, or psychological disorder causes the consumer to meet at least on of the following criteria:
    a). The consumer has undergone psychiatric treatment more intensive than outpatient care and more than once in a lifetime, such as emergency services, alternative residential living, or inpatient psychiatric hospitalization;
    b). The consumer has experienced a single episode of psychiatric hospitalization with an Axis I or Axis II diagnosis per the DSM-IV-TR;
    c). The consumer has been treated with psychotropic medication for at least one year; or
    d). The consumer has had frequent crisis contact with a center or another provider for more than six months as a result of a severe and persistent mental illness; and
2. The consumer's severe and persistent emotional, behavioral, or psychological disorder meets at least three of the following criteria:
    a). The consumer is unemployed or has markedly limited job skills or poor work history;
    b). The consumer exhibits inappropriate social behavior which results in concern by the community or requests for mental health or legal intervention;
    c). The consumer is unable to obtain public services without assistance;
    d). The consumer requires public financial assistance for out-of-hospital maintenance;
    e). The consumer lacks social support systems in a natural environment, such as close friends and family, or the consumer lives alone or is isolated; or
    f). The consumer is unable to perform basic daily living skills without assistance.

Based on the WICHE MH Estimation Project, estimates of need for mental health services for South Dakotans with severe and persistent mental illness are projected at 16,765.

Criterion 4: Targeted Services to Rural and Homeless Populations

The barriers faced in mental health service provision in the rural areas of the state are numerous and difficult to overcome. Several community mental health centers include vast land areas, which are sparsely populated. Three Rivers Mental Health and Chemical Dependency Center located in the northwestern portion of the State and Southern Plains Behavioral Health Services located in south central South Dakota face unique challenges in the delivery of mental health services due to the rural nature of counties in their catchment areas. Lack of transportation, high travel time for service providers, lack of appropriate housing and employment opportunities, and lack of financial resources to afford medications and basic necessities of daily life are some of the challenges faced by individuals. The lack of psychiatric services in rural and frontier areas of the State also poses significant challenges in providing a broad continuum of care.

The Division of Mental Health recognizes the obstacles to effective service delivery in rural and frontier areas. The division also recognizes that community mental health centers serving rural and frontier areas often struggle financially as their localities lack the population base to support services. In addition, travel time is not billable for CARE services despite the fact that case mangers may have to travel for hours to provide home/community-based services. Beginning in FY00, the Division of Mental Health added a rural rate to CARE services billable for services provided at a distance of at least 20 miles from a main or satellite office. This rate is 20% higher than the "regular" rate and allows better access to the funding allocated to community mental health centers. In FY02, the Division of Mental Health began allowing the CARE rate for Three Rivers Mental Health and Chemical Dependency and Southern Plains Behavioral Health Services to be billed entirely as rural. This adaptation has allowed for service delivery that better serves the needs of the population in these areas.

In addition to establishing the rural rate, the Division of Mental Health has also explored the feasibility of using telemedicine to address the shortage of psychiatric services across the state, especially in rural and frontier areas. In FY02, a budget increase in mental health block grant funding was targeted to support telepsychiatry services. This funding allowed Southern Plains Behavioral Health Services to implement a telepsychiatry pilot program, which provided needed psychiatric services to adults with SPMI and/or children with SED. The Division of Mental Health has monitored data from this pilot to determine the efficacy of telepsychiatry services. The Division of Mental Health also continued actively advocating for Medicaid reimbursement for telepsychiatry services. In March of 2004, pharmacological management provided by physicians became reimbursable by Medicaid when provided via telemedicine.

General housing issues are of concern in South Dakota, including those individuals with SPMI and SED who are homeless or at imminent risk of becoming homeless. According to Section 304® of the Public Health Service Act, a "homeless individual" is defined as an individual who lacks housing (without regard to whether the individual is a member of a family) including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. State fiscal year 2004 data shows

us that the number of individuals who are homeless and have mental illness in South Dakota is 2,603. Services provided to individuals who are homeless or at imminent risk of becoming homeless through the Projects for Assistance in Transition from Homelessness (PATH) include:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation services
- Staff training
- Case management
- Supportive and supervisory services in residential settings
- Referrals for primary health services
- Education services and relevant housing services
- Minor renovation
- Expansion and repair of housing
- Planning of housing
- Technical assistance in applying for housing assistance
- Improving the coordination of housing services
- Assistance with security deposits
- One-time rental assistance to prevent eviction
- Job training

All community mental health centers receive a portion of PATH funding to assist individuals who are in need of the services available through PATH. However, the bulk of PATH funding has been allocated to the two community mental health centers located in the more urban areas of Sioux Falls and Rapid City. Due to the larger population base and more metropolitan area of these cities, there is a higher percentage of homelessness, and therefore a greater need for PATH funding.

In addition to PATH funding, all community mental health centers provide assistance in locating and maintaining suitable living environments to individuals with severe and persistent mental illness. An important aspect of these services is the collaboration with the local and state housing authorities. Many of the housing facilitators and outreach workers serve as a liaison to the local housing authorities and community homeless coalitions.

During FY02, the Division of Mental Health hosted a PATH TA training "Implementing Interventions for Individuals with Co-Occurring Mental Health and Substance Use Disorders." This training was designed to assist providers in understanding co-occurring disorders and systems integration, particularly related to homeless individuals. During FY03, the Division of Mental Health hosted a second PATH TA training via teleconference. This training addressed collaborative relationships between mental health and substance abuse agencies. Training on co-occurring mental health and substance abuse disorders and the need for systems integration, formal cross-training/cross-staffing and effective treatment models were discussed. The training also focused on housing needs including the need to expand adequate housing opportunities and implement sufficient levels of supportive services to keep individuals housed.

The Division of Mental Health is acutely aware of the shortage of housing opportunities in the state for consumers and understands that this is an essential component of allowing individuals to remain in or return to their home communities. In FY03, The Division of Mental Health participated in the State's delegation to SAMHSA's Policy Academy on Chronic Homelessness. One of the objectives coming out of the Policy Academy was for South Dakota to develop an interagency council on homelessness. The Division of Mental Health in collaboration with South Dakota Housing Development Authority, community action agencies, shelters, domestic violence shelters, community mental health centers, consumers, etc. established a Statewide Continuum of Care. *The Housing for the Homeless Consortium* has laid the groundwork for ending chronic homelessness and designing an integrated system that will provide seamless services to individuals and families experiencing homelessness. This group of public and private organizations has been meeting monthly for approximately three and a half years to coordinate this effort. The Division of Mental Health State's PATH Contact has participated in all National PATH Teleconferences dealing with the SuperNOFA application and has shared technical assistance information with the Statewide Continuum of Care Network. The Division of Mental Health is represented on the Planning and Advisory Committee (PAC) which advises the Consortium in the direction it believes the organization should move and develops the criteria used to assess and prioritize the housing proposals to be funded through HUD (Housing and Urban Development). The Division will continue to be a part of this effort and will also encourage PATH providers to become involved. South Dakota is in the process of completing its fourth year application that is due on July 15, 2004.

Criterion 5: Management Systems

Targeted amounts in the FY05 budget specifically for services for adults with severe and persistent mental illness are $11,517,121 which includes Medicaid, block grant, and state general funds. The budget includes services provided through the CARE and IMPACT Programs, Serenity Hills, and residential (room and board) for targeted populations. The entire community-based budget is $21,432,326 and includes services to individuals with SPMI, SED, as well as other services such as outpatient, emergency, protection and advocacy, and the indigent medication program. Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council at their quarterly meetings.

Medicaid is a vital funding component of South Dakota's system of mental health care. On July 1, 1995 the Mental Health Rehabilitative Services Option was added to the Medicaid State Plan. Community mental health center services, previously restricted under the Clinic Option, became much more flexible under the Rehabilitation Option. This transition allowed service provision outside the clinic setting and provided a significant enhancement of service capability, especially in rural communities where transportation options are limited or non-existent. The Rehabilitation Option also allowed the implementation of community-based services, which are more accessible and responsive to individual consumers.

The Department of Social Services' budget includes a federally mandated state general fund match to federal Medicaid dollars to provide medical services to individuals who are Medicaid eligible. Established through a memorandum of understanding with the Department of Social Services, the Division of Mental Health's budget includes the federally mandated state general fund match to federal Medicaid dollars to provide mental health services to individuals who are Medicaid eligible.

CARE and IMPACT Program services are funded through a daily rate, which is paid for a billable service that is provided for a minimum of 15 minutes. Emergency services are also provided through purchase of service agreements with the eleven CMHCs. Each agencies total contract amount is pro-rated into twelve monthly payments. Evaluation of current rates is part on an ongoing process through the Financial Workgroup. This group is comprised of the Division of Mental Health, Department of Human Services fiscal staff community mental health center representatives and works to determine if current rates meet the costs of providing services. In FY02 this resulted in the establishment of a new rate for the CARE Program that "carved out" the psychiatric and CNP/PA services from the CARE daily rate. This has allowed community mental health centers to bill for both a psychiatric and a CARE contact on the same day. It has also allowed the psychiatric and CNP/PA components to maximize third party reimbursement whenever possible.

Establishing an organized system of care requires a planning process with the involvement of consumers receiving services, family members of consumers, mental health service providers, other service providers and purchasers. The statutorily defined membership of the Mental Health Planning and Coordination Advisory Council provides a mechanism to define and prioritize needed services as well as a vehicle to collectively

evaluate the system. This role is clearly defined in South Dakota Codified Law 27A-3-1.3-5, inclusive.

The Mental Health Planning and Coordination Advisory Council meets quarterly to evaluate and plan services for the target populations. Committees have been established to develop specific initiatives towards better service provision. The Council is also charged with submitting a written report to the Governor by December 1st of each year. The report reflects the systems progress in implementing the State Plan.

The DMH and the Mental Health Planning and Coordination Advisory Council have worked as a team to design and develop the system of mental health services for children and adults. As a result of this partnership the following principles and values will guide the development and implementation of key features of state funded mental health services: services be client-centered and needs driven; services be home and community-based; interagency linkage; networks and resources to provide a comprehensive array of appropriate treatment and rehabilitation services; services be outcome-based, responsive and innovative; and public education and awareness to increase the understanding of mental illness.

To ensure the involuntary commitment process is being handled appropriately, the Division of Mental Health offers a Qualified Mental Health Professional Endorsement, which allows qualified individuals to perform the mental health status examination prior to the involuntary commitment of an individual. During the 2003 Legislative Session, the legislature changed the statute to allow additional professionally licensed individuals to become Qualified Mental Health Professionals (QMHPs). The professionals added were Licensed Professional Counselors or Licensed and Certified Social Workers employed by the State of South Dakota or community mental health centers and Licensed Marriage and Family Therapists (LMFTs). Prior to this change, individuals licensed as LPCs had to have the mental health designation (LPC-MH) and LMFTs did not qualify to become endorsed as QMHPs. The addition of these professionals will assist in overcoming the rural issues of the state when individuals are faced with involuntary commitment. There are now 284 individuals endorsed as QMHPs in the State of South Dakota.

FY2005 Proposed Intended Use Plan

Activities funded by FY2005 CMHS Block Grant will fund:

Activity	Amount
Administration	
SPMI Adult Mental Health Services	
SED Children's Mental Health Services	
Total	

Community mental health centers which will receive FY2005 Block Grant funds and projected amounts:

Community Mental Health Center	Adult SPMI	Children's SED	Total
Behavior Management Systems			
Capital Area Counseling			
Community Counseling Services			
Dakota Counseling Institute			
East Central Mental Heath Center			
Human Service Agency			
Lewis & Clark Behavioral Health Services			
Northeastern Mental Health Center			
Southeastern Behavioral Healthcare			
Southern Plains Behavioral Health Services			
Three Rivers Mental Health Center			

FY2006 Proposed Intended Use Plan

Activities funded by FY2006 CMHS Block Grant will fund:

Activity	Amount
Administration	
SPMI Adult Mental Health Services	
SED Children's Mental Health Services	
Total	

Community mental health centers which will receive FY2006 Block Grant funds and projected amounts:

Community Mental Health Center	Adult SPMI	Children's SED	Total
Behavior Management Systems			
Capital Area Counseling			
Community Counseling Services			
Dakota Counseling Institute			
East Central Mental Heath Center			
Human Service Agency			
Lewis & Clark Behavioral Health Services			
Northeastern Mental Health Center			
Southeastern Behavioral Healthcare			
Southern Plains Behavioral Health Services			
Three Rivers Mental Health Center			

FY2007 Proposed Intended Use Plan

Activities funded by FY2007 CMHS Block Grant will fund:

Activity	Amount
Administration	
SPMI Adult Mental Health Services	
SED Children's Mental Health Services	
Total	

Community mental health centers which will receive FY2007 Block Grant funds and projected amounts:

Community Mental Health Center	Adult SPMI	Children's SED	Total
Behavior Management Systems			
Capital Area Counseling			
Community Counseling Services			
Dakota Counseling Institute			
East Central Mental Heath Center			
Human Service Agency			
Lewis & Clark Behavioral Health Services			
Northeastern Mental Health Center			
Southeastern Behavioral Healthcare			
Southern Plains Behavioral Health Services			
Three Rivers Mental Health Center			

Section II: Identification and Analysis of the Service System's Strengths, Needs and Priorities – Children's Mental Health System

Strength and Weaknesses of the Service System

The Division of Mental Health has identified numerous strengths and weaknesses of the community-based mental health system.

Strengths

The Division of Mental Health and the Mental Health Planning and Coordination Advisory Council have worked together in identifying system needs. The Division of Mental Health and the Advisory Council have developed a very close working relationship, recognizing the importance of all stakeholder involvement in strategic planning processes. The Advisory Council is very involved in development of goals and objectives associated with the CMHS Block Grant and provide ongoing feedback to the Division of Mental Health regarding issues related to service delivery within the community-based mental health system.

The Division of Mental Health was fortunate to be involved in a Policy Academy on Co-Occurring Disorders offered by SAMHSA. The Division of Mental Health, along with the Division of Alcohol and Drug Abuse, the Department of Human Services, the Governor's office, service providers and consumers are all actively involved in the development of integrated treatment for South Dakotans with co-occurring disorders. With buy-in to these services from so many stakeholders, the Division is optimistic that integrated treatment for individuals will become a reality within a few years.

The Division of Mental Health provides funding for a statewide Indigent Medication Program. The Indigent Medication Program provides temporary funding to assist individuals in purchasing their medications and/or labs when they have no other means to do so.

The community mental health centers and the Division of Mental Health share a close relationship and work together to develop outcome measures and components of service delivery for individuals with severe and persistent mental illness. This relationship is helping to shape the development of comprehensive mental health services across South Dakota.

Weaknesses

The combination of poverty and remoteness facing rural areas presents additional challenges in the provision of mental health care. A shortage of providers, along with transportation issues, makes access to services difficult. Issues with appropriateness and

access to services for individuals in rural areas are always in the foreground during discussions the Division has regarding service delivery.

There is a definite shortage of housing opportunities for consumers within the state. Many communities lack the low income housing options and/or supervised living options for individuals that cannot live independently.

The current caseloads for case managers at community mental health centers are high. Staff turnover at community mental health centers remains a concern due to continuity of care for individuals needing mental health services.

The current community based mental health system is not oriented towards recovery. The Division will need to take the lead in transforming the mental health system from a maintenance system to a more recovery focused system. The Division of Mental Health will also look to the Mental Health Advisory Council and family members/consumers to provide valuable input into the system change process.

Unmet Needs and Critical Gaps

During the last few years, the Division has been looking closely at the management information system (MIS) and its capabilities in reporting data, along with what data was currently being collected and if that data was being used in strategic planning and policy decisions. The Division of Mental Health found that it does not currently have a process in place for analyzing data collected/reported for Block Grant and outcome purposes. The Division has numerous ways to receive data, but we do not have a process to actually analyze data and base policy decisions or strategic analysis on information gathered.

Although there are evidence-based practices within the State, there is no process in place to measure fidelity of these practices. Furthermore, there may be confusion within provider agencies regarding exactly what definitions of evidence-based services are, whether the current services meet that fidelity, and what is required for a program to maintain fidelity to an evidence based practice.

Accreditations of community mental health centers are currently only administrative in nature. They do not include outcome-driven qualitative data. The Division of Mental Health currently does not have a way to collect qualitative information, which could give us a better idea of appropriateness and quality of mental health services across the State.

Local provider infrastructure needs are not compatible with State office infrastructure for accurate data recording/reporting. The Division of Mental Health has used the first Data Infrastructure Grant to update the MIS system to reflect the changing reporting needs for CMHS and State requirements. With the new MIS system, the Division must work to ensure that local provider's infrastructure will meet the needs of the State.

The community-based mental health system currently has waiting lists for individuals needing mental health services. Hand in hand with this is the current high caseload for

case managers and staff turnover issues. Workforce development is a major concern for the Division of Mental Health, and is consistently an issue that is addressed in discussions with various stakeholder groups, including the Mental Health Planning and Coordination Advisory Council.

Access to services throughout South Dakota is an issue, but especially in the very rural/frontier areas of the state. Some areas served by the community mental health centers encompass great distances. These areas have difficulty attracting qualified professionals, along with having limited financial resources to provide access to mental health services.

Priorities and Plans to Address Unmet Needs

Through strategic planning, the Division of Mental Health and the Mental Health Planning and Coordination Advisory Council have identified needs and priorities for the community mental health system for the next three years. To begin this process a vision statement was created – "South Dakota will promote prevention and recovery through an integrated mental health system that provides access to a continuum of services and supports that allow full participation in the community." The President's New Freedom Commission on Mental Health's final report drove the process of planning for ways to improve the system of care for individuals with mental illness. The goals identified as priority areas include the following:

- Goal 2: Mental Health Care is Consumer and Family Driven
  - 2.5 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
  - 2.6 Involve consumers and families fully in orienting the mental health system toward recovery.
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
  - 4.3 Promote the mental health of young children.
  - 4.5 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Cultural competency will be addressed within each of the goals. Please see the sections on **"Recent Significant Achievements"** and **"The Future"** for a more in-depth discussion of the priority areas identified and specific goals and objectives attached to each area.

Recent Significant Achievements

The Unified Judicial System (UJS) and community mental health center directors have collaborated to improve the referral and service delivery system for children who are referred by UJS to a community mental health center. A memorandum of understanding (MOU) has been drafted and addresses the following: 1) procedures for transacting

standardized referrals for children's mental health services from the courts to respective community mental health centers; 2) practices for minimizing "no shows" among referred children/families; and 3) principles for assuring effective co-management of referred children/families. The Unified Judicial System and community mental health center directors will track the effectiveness of this process throughout FY04. In addition, Child Protective Services (CPS), community mental health center directors, and the Division of Mental Health began working in FY04 to establish more coordinated services for children referred by CPS. This will be accomplished by: 1) the development of a uniform intake/referral process for mental health services (similar to the MOU with UJS); 2) the development of a uniform referral/follow-up process for child abuse assessments; 3) the adoption of principles for the co-management of referrals; and 4) the identification of service gaps.

The Division of Mental Health continues to focus on interagency collaboration, which not only fosters a system of care but also ensures individuals are able to access appropriate services across agencies. Towards this end, the Division of Mental Health is participating in an effort to create a statewide suicide prevention and intervention plan. The suicide prevention stakeholder group began meeting in November 2002 and is comprised of public, private, and legislative members. Legislative support was also shown through the passage of Senate Concurrent Resolution No. 5 during the 2003 Legislative Session. This resolution supports the creation of a South Dakota plan for suicide prevention. It is anticipated that the statewide plan will be finalized prior to the 2004 Legislative Session. The statewide workgroup hopes to have the suicide prevention plan completed by late summer 2004. Next steps for implementation of the plan include: developing a community toolbox to assist communities in developing local prevention and intervention plans.

The 2003 SD legislature passed two bills that have brought the State of South Dakota back into compliance with the Juvenile Justice and Delinquency Prevention Act. The Council of Juvenile Services was reconstituted as part of this compliance. This group has identified several issues that it plans to address for purposes of future juvenile justice development within the State. Mental health services were one of the key areas identified, and the Systems and Services Committee has been tasked with assessing the juvenile service needs in a variety of areas (including mental health). The committee will make recommendations to the full Council on new programs to be developed and funded with formula grants.

The Division of Mental Health has also been asked to participate on a task force that is required by the Children's Justice Act (CJA) in order to receive grant funds under the CJA. The State of South Dakota will receive Children's Justice Act (CJA) grant funds that are to be used for programs to reform State systems and improve the processes by which States respond to cases of child abuse and neglect, particularly child sexual abuse and exploitation and cases of suspected child abuse or neglect related to fatalities. This funding will enable South Dakota to deal more effectively with both the child victim and offender and to limit additional trauma to the child victim.

Education and training provided to the Mental Health Planning and Coordination Advisory Council has been essential in keeping members informed on various topics. During FY04, one of the quarterly council meetings was held in Yankton, SD. This allowed council members to attend the annual Yankton Mental Wellness conference, as well as tour the Human Services Center. Other training opportunities included regular presentations at council meetings. These presentations included:

- Eileen White – "In Our Own Voice: Living with Mental Illness," which provides an example of recovery from severe and persistent mental illness from the perspective of an individual living with mental illness. Eileen also presents this program (along with the Division of Mental Health and the Department of Human Services legal counsel) at quarterly law enforcement training courses. The goal of the mental health component of the training is to give law enforcement officers a better understanding of mental illness and application of this knowledge when in the field. Along with these activities, the Division of Mental Health has been able to assist in funding for Eileen to carry the "In Our Own Voice" message to numerous community groups including employers, consumer groups, and other state agencies. Eileen has also spoken to students in several South Dakota high schools. This has allowed an additional component to public education that has become very important to continue.
- Dennis Mohatt, an expert consultant to the President's New Freedom Commission on Mental Health on rural issues, presented on the final report of the President's Commission on Mental Health.
- Brenda Freeman provided the council with a cultural competency training presentation, which included key components and promising practices of cultural competence in the delivery of mental health services to American Indians.
- Barry Pillen with the Division of Alcohol and Drug Abuse shared information on the use of methamphetamines in the state.
- Jim Hagel and Dr. Mark Gary – services provided by Indian Health Services (IHS) and the history of the Indian Insane Asylum in Canton, SD.
- Roy Conrad – a presentation on using play therapy with young children.

Additional training provided through the Department of Human Services includes Division of Mental Health and Human Services Center staff presenting at the NAMI-SD annual conference.

An important workforce development activity relates to a federal grant the Division of Mental Health was awarded in FY03. This grant will be used to assist in building the emergency response capacity of mental health and alcohol and drug personnel, as well as other first responders in communities. Training in the Critical Incident Stress Management (CISM) model and the development of South Dakotans able to be CISM trainers will be major activities of the grant.

The Division of Mental Health has partnered with the South Dakota Coalition for Children on a project to increase public awareness of children's mental health issues in South Dakota. See the next section (The Future) for more information regarding this project.

The Division of Mental Health understands the importance of developing systems of care that deliver effective and comprehensive mental health and support services for adults with severe and persistent mental illness and children with serious emotional disturbances. The following information and activates are part of the development of this system of care.

- The Legislature of the State of South Dakota passes House Bill 1132 in 2002 which established a Children's Mental Health Task Force. The purpose of the Task Force was to evaluate the current mental health system for children in SD and provide recommendations for system improvements to the Seventh-eighth Legislature. The legislative action initiating the Children's Mental Health Task Force is indicative of an evolving understanding among public policy makers that the current system is falling short in its ability to effectively meet the needs of children with serious emotional problems and their families. The Task Force recommendations address critical needs such as options for parents/families of children with SED to obtain public services without relinquishing custody, early identification ad intervention services, knowledge regarding the need for help and where to obtain such help, systems of care and a continuum of services, and an adequate workforce. Steps have been taken to begin addressing the recommendations and fill the service gaps in the current system. Additional information regarding these steps is included in the next section – "The Future."
- A Clinical Management Team was created by community mental health center representatives for the purpose of analyzing the current community mental health center clinical services system. Priority areas include promoting strength and family-focused services, adopting evidence-based practices, increasing staff training opportunities, and strengthening relationships between community mental health centers and community agencies. See the section titled "The Future" for further information.
- The Division of Mental Health is collaborating with Child Protective Services (CPS) to offer mental health services targeted to families with children who are at risk of being removed from their families. The purpose of these services is to intervene early with families who are involved with CPS and prevent out-of-home placement or reunify families when this has occurred. During FY04, the Division of Mental Health expanded this program to a second community mental health center. These programs have proven to be effective in keeping children in their homes and successfully reuniting children and families when this has occurred. It is planned that this service will be expanded in the future as funding and needs dictate.
- The South Dakota Alliance for Children: Supporting Child Care, Early Education and School-Age Care was established in 2002 as a statewide coalition of organizations, providers, professionals, and parents advocating for policies, programs, and funding that will achieve an affordable, seamless, unified, high quality child care and early education system in SD for children birth through eighth grade. The Alliance membership includes the Division of Mental Health and a goal of supporting the healthy development of children in early childhood settings. An objective of this goal is to develop consultation services through community mental health centers designed to support the social emotional issues of children in child care settings, focusing on birth to five. The Division of Mental Health has been collaborating with the Office of Child Care Services to utilize funding in a manner that will allow mental health

centers to consult with childcare providers to assist those providers in better serving children with emotional and behavioral issues. In FY04, the Division of Mental Health targeted additional funding to three mental health centers for services provided to children age five and under with SED. In FY05, the Office of Child Care Services has secured funding to support consultation services to childcare settings in four pilot sites which will assist childcare providers in effectively working with children in their care. The Division of Mental Health and the Office of Child Care Services will evaluate the effectiveness of this collaboration and combination of funding streams and will look to expand the services as needed.

- The 2004 Legislature passed Senate Bill 117 to establish a task force to improve the quality and availability of child care and early learning opportunities in South Dakota. An 18 member task force has been appointed and includes representation from the Division of Mental Health. The task force will evaluate current provision of services, gaps and barriers to quality child care, and national best practices and incentives to improve quality. A report of findings and recommendations for improvement will be presented to the Eightieth Session of the Legislative Assembly. The Division of Mental Health recognizes the importance of quality child care and early learning in children's social/emotional development. This is an important component in promoting the mental health of young children, particularly in the areas of prevention and early identification/intervention.
- The Division of Mental Health has also been asked to be part of the South Dakota team on the National Infant and Toddler Child Care Initiative (Zero to Three). This initiative is a project of the Child Care Bureau, Administration for Children and Families, and its mission is to work collaboratively with state child care administrators in their efforts to help move forward system improvements in infant and toddler child care. The SD team will determine the current state of infant/toddler services and how to make improvements to the system. This is seen as another important component in the social/emotional development of young children.
- The South Dakota Council of Mental Health Centers secured a grant in the fall of 2003 form the federal Office of Juvenile Justice and Delinquency Prevention to provide enhanced services to at-risk youth and families residing in South Dakota's most "difficult to reach" locations. Grant supported activities will target youth who are already involved or are at risk of involvement with the state's juvenile justice system. During the two year grant period, ten mental health centers will provide one or more of the following services to individuals in very rural areas of the state: 1) Wraparound services for youth and families; 2) School-based/linked mental health services; 3) Community development/coordination projects; and 4) Professional training/development for rural/frontier service providers.
- Children and family services and the need for family support services for children with special needs are part of the Department of Human Services strategic plan. Included in this is the need for improved coordination of existing services both within the Department of Human Services as well as with other departments and agencies.

The Future

Integration of mental health and substance abuse services for individuals with co-occurring disorders has been identified by the Mental Health Planning and Coordination Advisory Council and the Division of Mental Health as a priority area. Towards this end, the Department of Human Services applied for a SAMHSA Co-Occurring Disorders Grant during FY04. Through this grant, South Dakota intended to address gaps in services for individuals with co-occurring disorders through an interactive process of infrastructure development and implementing SAMHSA capacity building goals of training, screening, and assessment. The State's plan followed a logical, sequential process of 1) statewide consensus building, 2) infrastructure development, 3) pilot studies, and 4) regional expansion. Multi-agency collaboration and ongoing project evaluation were also core components. The Department of Human Services has been successful in securing funding to complete a provider readiness assessment, which will provide essential information as South Dakota moves forward with the integration of mental heath and substance abuse services.

The Division of Mental Health, the Division of Alcohol and Drug Abuse, the Secretary of the Department of Human Services, provider agencies for substance abuse and mental health, the Governor's office and consumers/family members had the opportunity to take part in a SAMHSA-sponsored Policy Academy on Co-Occurring Disorders in 2004. This Policy Academy allowed the State to bring together a group of individuals that can effect change in provision of services to individuals with Co-Occurring substance abuse and mental health diagnoses across the state. An Action Plan was developed (see Attachment 10) to address issues around delivery of services to individuals with Co-Occurring Disorders. The Division of Mental Health will play an important role in developing a strategic plan for comprehensive services for individuals with Co-Occurring Disorders.

Another part of the effort to begin movement towards integrated mental health and substance abuse dual diagnosis programs is collaboration between the Division of Mental Health and the Division of Alcohol and Drug Abuse to develop a more comprehensive Management Information System (MIS). In 2001, the Division of Mental Health was awarded a Data Infrastructure Grant. This grant was created to assist states in developing management information systems (MIS) that have the capability of measuring performance outcomes and reporting on the additional basic and developmental measures developed by CMHS. Due to the antiquated nature of the Division of Mental Health's current MIS, reporting capabilities have been limited in the past. The new MIS will be web-based and will allow both divisions to collect the data necessary to measure outcomes in the community-based systems, as well as meet all HIPAA and federal reporting requirements. The development and implementation of the MIS will continue throughout FY05 and FY06.

Implementing person-directed services throughout the Department of Human Services to improve service satisfaction, cost effectiveness, and quality of services is a goal identified by the department. This would be accomplished with input and participation from

service recipients/family members and would result in statewide implementation throughout all divisions within the Department of Human Services. This goal also includes the need for services that are culturally competent and responsive to individual needs. The Division of Mental Health and the Advisory Council recognize the importance of consumer/family-driven, strength-based, recovery-oriented treatment. Developing an individualized plan of care for every child with a serious emotional disturbance will assist in moving the system towards recovery and will allow families to actively participate in treatment and recovery. The involvement of consumers and families in the move to orient the system towards recovery will be crucial, and the Division of Mental Health will work to involve and support consumers/families in this system transformation. During FY05, the division with input from the Advisory Council will work to enhance the Accreditation Review process to include a focus on individualized planning and recovery. Components that may be added to the reviews include life quality and peer review elements. The addition of a consumer and/or family member on the review team will also be explored along with the possibility of involving consumers/family members in the training of providers. The Advisory Council also discussed the possible benefits of having a consumer/family liaison within the Division of Mental Health so this will be discussed further as well. By FY06, the updated review process will be implemented throughout the community mental health system. During FY06 and FY07, the division will evaluate the process and make changes as needed. A tool that may assist with these plans is the Data Infrastructure Grant on Quality Improvement.

The Division of Mental Health submitted an application to SAMHSA for the Data Infrastructure Grant on Quality Improvement. This grant will allow the Division to build infrastructure between local providers and the State infrastructure systems to more accurately collect/report data for the CMHS Block Grant and URS Table reporting. This grant will also allow the Division to look at building and maintaining fidelity to evidence-based services being provided across the State. The Division of Mental Health use this grant to assist in refining the community mental health center accreditation process to include outcome driven performance indicators and more fully involve consumers and family members in delivery of mental health services Statewide. The Data Infrastructure Grant on Quality Improvement will continue throughout FY05-FY07.

The SDCMHC Clinical Management Team is committed to family-focused intervention that provides youth and families a strength-based, team-initiated multilevel change process focusing on multiple community and family systems, family and individual functioning, and clinicians as major contributors to both the problems as they are identified and solutions that work. Core values of the System of Care as identified and embraced by the Advisory Council, CMT, SD Council of Mental Health Centers, and the Division of Mental Health include:

- The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- The system of care should be community-based, with the locus of services as well as management and decision making responsibility resting at the community level.

- The system of care should be culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

To begin the process of implementing Systems of Care, the CMT has identified minimum skill and duties required for intensive case management. A statewide kick-off training on Systems of Care and the components of intensive case management will be held in October 2004. This training will include all community mental health center therapists and case managers who work in children's services and is seen as the first step in developing Systems of Care. The Advisory Council also highlighted the importance of conducting appropriate, strength- and family-based assessments as a key area in establishing individualized plans and providing appropriate services. Training in appropriate assessments will also need to be addressed through the trainings related to intensive case management and systems of care. To further enhance the training aspect, the Division of Mental Health and WICHE have developed a proposal to continue training beyond the kickoff event. In addition, the Advisory Council discussed involving family members and consumers in training efforts, both in receiving training themselves and in providing training to mental health center staff. Discussions will continue regarding ways to incorporate these elements into the Systems of Care development.

The development of Systems of Care will begin with the intensive case management component. The Division of Mental Health will seek additional funding in the FY06 budget request to support targeted staff to provide intensive case management services. If the funding request is successful, the division will monitor and evaluate the effectiveness of such services throughout FY06 and work to expand intensive case management as needed in FY07. During this time, the division will also work with community mental health centers to further the development of Systems of Care by collaborating with other providers, school systems, family members, and other supports through child/family teams. This collaboration was deemed critical by the Advisory Council in establishing individualized plans of care and appropriate service delivery. Another System of Care component identified as critical by the Advisory Council is the need for services to be home-and community-based. The reimbursement of telepsychiatry will assist with this component. The Division of Mental Health will also need to work with community mental health centers to determine methods of ensuring mental health services are available to all South Dakota residents, including those residing in frontier areas of the state.

The Divisions of Mental Health and Alcohol and Drug Abuse jointly applied for a Child and Adolescent Mental Health and Substance Abuse State Incentive Grant. If funded, this would provide for infrastructure development to support a system of care for children and adolescents with mental health and/or substance abuse and their families to access appropriate services in their communities and avoid out-of-home placement. Building systems of care that include key elements such as service coordination, family involvement, and culturally competent services are critical to the well-being of children with mental health and/or substance abuse disorders in SD.

The Division of Mental Health has partnered with the South Dakota Coalition for Children on a project to increase public understanding of children's mental health and the efficacy of early screening and treatment. This project will allow for the creation of a multi-faceted, comprehensive public awareness plan that will be created through a collaboration of public and private stakeholders. Such a plan will set the course for ensuring parents, professionals, and children themselves are better able to determine when to seek mental health services and thus prevent the need for more costly treatment options. Funding for an initial planning summit has been obtained. This summit will take place in the fall of 2004 and will bring together key stakeholders to develop a South Dakota-specific multi-year public awareness plan on children's mental health. Specific tasks regarding the public awareness plan will be included in updates to this multi-year State Block Grant application.

As noted in the "Recent Significant Achievements" section, throughout FY05 the Division of Mental Health will be involved in several projects regarding the healthy development of young children. These activities will assist the division in promoting the mental health of young children by highlighting the importance of social/emotional development, as well as collaborating with other systems to begin the work towards a "no wrong door" approach. The Advisory Council highlighted training/education on early childhood development, particularly social/emotional development and the "no wrong door approach as a key areas in promoting the mental health of young children. During FY06 and FY07, the Division of Mental Health will work to expand these efforts to additional systems such as healthcare. This coordination will assist in the early identification of young children with mental health needs through wellness checks and other routine healthcare related visits.

In addition to collaborations with entities such as the Office of Child Care Services, Zero to Three, and the Child Care and Early Learning Opportunities Task Force, the Advisory Council highlighted the importance of partnering with school systems to work towards the goal of promoting the mental health of young children, particularly in the area of early identification and intervention. Relative to this area, the council focused on the possibility of incorporating a mental health component into kindergarten screenings. The Division of Mental Health will begin exploring the feasibility of such screenings with the Department of Education and the community mental health system during FY05. By FY06, the Division of Mental Health plans to have a pilot established where kindergarten screenings in a school district would include a mental health component. During FY07, the division will work to expand the pilot to include several districts with statewide implementation to follow.

The Division of Mental Health has recently submitted an application to SAMHSA for the Data Infrastructure Grant on Quality Improvement. This grant will allow the Division to build infrastructure between local providers and the State infrastructure systems to more accurately collect/report data for the CMHS Block Grant and URS Table reporting. This grant will also allow the Division to look at building and maintaining fidelity to evidence-based services being provided across the State. Along with accomplishing the above goals, the Division of Mental Health will begin to look at transforming the community-based mental health system into a more consumer/family oriented outcomes system. The

Division of Mental Health will look at refining the community mental health center accreditation process to include outcome driven performance indicators and more fully involve consumers and family members in delivery of mental health services Statewide.

SD Health Care Commission was created by the 2003 legislature and charged with gathering data to assess the health status of South Dakotans, identifying health care priorities that address financing, delivery and programming, and developing measurable health outcomes for selected state initiatives for health care. The legislature also directed the commission to recommend health care policy, monitor health care environments, and address the health care needs of South Dakotans. Representation on the commission includes business and employers, consumers, insurers, health care providers, public and community health workers, the Governor's office, former legislators, tribal members, mental health providers, and the Indian Health Service. Mental Health has been identified as a key area and the Division is playing an active role in Depression subcommittee that has been formed.

Comprehensive NeuroScience, Inc. (CNS), through grant funding from Eli Lilly, will assist South Dakota in a project designed to improve the quality of behavioral health prescribing practices based on best practice guidelines; improve patient adherence to medication plans; and improve the effectiveness of the dollars spent on Medicaid behavioral drugs. The process will include CNS collecting data from the State Medicaid Office to determine how physicians are prescribing behavioral health medications. This data will be analyzed and a steering committee will establish priority areas that will be targets for quality improvement strategies such as a Quality Alert Package to prescribers, educational briefs, normative report cards and peer-to-peer contacts. The Division of Mental Health will be involved in this project over the next couple of years.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The Division of Mental Health, in conjunction with the Mental Health Planning and Coordination Advisory Council, has the responsibility to establish a system of public mental health services to meet consumers' needs. Through purchase of service agreements with eleven non-profit community mental health centers, the Division of Mental Health provides Children's SED Program services to targeted populations (i.e., children with SED and their families). The agreements with community mental health centers also include the provision of outpatient services to non-targeted populations. In addition, each community mental health center receives a monthly allocation of state general funds to support emergency services based on the population of their respective catchment areas.

The children's SED program is an intensive and comprehensive, child-centered, family-focused, community-based, individualized system of care that delivers mental health services to children with serious emotional disturbances. The SED program provides access to a comprehensive array of services that address a child's physical, psychological, emotional, social and educational needs. The program provides children with individualized services in accordance with the unique needs and strengths of the child. These services are provided to SED children within the least restrictive, most normative environment that is clinically appropriate and in a manner that is sensitive and responsive to children's cultural differences and special needs. Parents, families, and other child-serving agencies are full participants in all aspects of the evaluation, planning, and delivery of SED services. The goal of these services is to ensure that children with SED are able to live with their families in their home communities whenever possible. The broad range of services that are provided through the children's SED program are listed below.

- In-Home and Community-Based Individual Therapy
- In-Home Family Education/Support/Therapy
- Case Management
- Assessment and Evaluation
- Psychological Evaluation
- Group Therapy
- 24-Hour, 7-Day Crisis Response
- Liaison Services
- PATH Housing Funds
- Respite Care
- Collateral Contacts
- Intensive Family Services

A case manager is assigned to the child/family after the diagnostic/needs assessment is completed. The case manager will access and coordinate services on behalf of the family. Generally, the case manager will be a staff person working with the family in addition to the therapist. The therapist may be the case manager if the family's needs

would best be met by working with only one staff person or if the family requests that the therapist assume both roles. The case manager will be a staff member of the community mental health center who will partner with the family to complete the following activities:

1) Assist the family and the child in identifying child and family needs and strengths;
2) Create a strength-based, outcome-focused case service plan using a team approach involving the child, family, and involved service providers;
3) Assist the family in accessing other resources in the community, as necessary;
4) Advocate on behalf of the family; and
5) Coordinate services on behalf of the family within the mental health center and with other child-serving agencies in the community and surrounding area.

Part of these case management services may include employment services, if an adolescent desires employment. Such services might include assisting the individual in locating, securing, and maintaining employment or assisting the individual in accessing services through other agencies or programs. An example of linking individuals to another agency is through a program entitled *"Project Skills."* The State Vocational Rehabilitation (VR) Agencies, Division of Rehabilitation Services (DRS) and Services to the Blind and Visually Impaired (SBVI), fund this program to address the need for students with disabilities to get an opportunity to gain paid employment while in high school. Project Skills is a cooperative arrangement between the State VR Agencies and the local school systems. The State VR Agencies fund the wages, workers compensation, and FICA while the schools provide the job development, job coaching, and follow-along for the student at the job site. This allows students with disabilities to take advantage of an important learning, maturing, and socializing experience.

Case management services also include working with other agencies that may be involved with the child and family, such as coordination with school systems to ensure children are properly served under the Individuals with Disabilities Education Act and/or working with social services or juvenile justice agencies to help keep families together and children in their homes. Both the community mental health system and the Division of Mental Health have a strong commitment to provide the services necessary to maintain family structure and keep children in their homes and communities.

When it becomes necessary for children to be placed outside of their homes, it is essential that appropriate services are delivered to the families to prepare them for the child's return. The Intensive Family Services (IFS) program is provided jointly by the Departments of Corrections, Labor, Social Services, and Human Services (see Attachment 6). This pre-aftercare program is a multi-dimensional effort of various state agencies to provide an opportunity to families of youth who are place under the jurisdiction of the Department of Corrections to address issues and access needed services to allow their children to return their homes with the greatest opportunity for success. The purposes of IFS are:

- To asses the ability of the parent(s) and family to serve as an appropriate placement resource for the youth upon release;

- To reduce or eliminate issues present within the family that may contribute to or allow delinquent behaviors;
- To promote the successful reintegration of the youth into their family upon their placement in the home upon release; and
- To reduce the likelihood of redicidivism of the youth to the correction system through improved family functioning.

The community mental health centers provide services to eligible families based upon an assessment of needs. These services specifically address issues that may negatively affect reunification of the absent youth and the youth's family.

The Division of Mental Health has committed general funds to implement an indigent medication program that provides psychotropic medication to individuals who have no other means of acquiring their medication. In SFY99 funding was targeted to adults with SPMI who have had repeated admissions to HSC and those individuals released from HSC on forced medication orders. In SFY00, the DMH was able to secure increased general fund dollars to expand the program to provide medication funding to children with SED. These funds are also used to provide necessary blood draws to monitor side effects, and staff to assist with medication administration and monitoring. This program compliments ongoing efforts to utilize pharmaceutical company programs and other alternatives for medication funding. Through the indigent medication program, the DMH hopes to see a decrease in the number of individuals hospitalized due to inability to secure medication.

The shortage of psychiatric services across the state, especially in frontier areas, continues to be an area of concern related to the accessibility of services. The provision of psychiatric services through telemedicine is empirically proven, yet underutilized in South Dakota. During FY04, telepsychiatry services continued to be piloted in one area of the state through Block Grant funding. The Division of Mental Health also continued to actively advocate for Medicaid reimbursement for telepsychiatry services. In March of 2004, pharmacological management provided by physicians became reimbursable by Medicaid when provided via telemedicine.

Criterion 2: Mental Health System Data Epidemiology

The Division of Mental Health provides mental health services to children with severe emotional disturbances (SED), as indicated by

1. The individual is between 0 and 18 years of age or is between 18 and 21 years of age and needs a continuation of services that were started before the age of 18 in order to realize specific service goals or during transition to adult services; and
2. The individual exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family or peer group; and
3. The individual has a mental disorder diagnosed under DSM III-R or DSM-IV (V Codes not included); and
4. The individual demonstrates a need for one or more special care services, in addition to mental health services; and
5. The individual has problems with a demonstrated or expected longevity of at least one (1) year or has an impairment of short duration and high severity

Based on the WICHE MH Estimation Project, estimates of need for mental health services for South Dakota children with serious emotional disturbance are projected at 15,453.

Criterion 3: Children's Services

The Division of Mental Health, through the Children's SED Program, promotes the provision of mental health services in a community setting with hospitalization or other out-of-home placement being the choice of last resort. SED services include case management services to assist the child and family with the identification of strengths and needs to create a strength-based, outcome-focused case service plan. Services are provided using a team approach involving the child; family; other service providers such as social services, education, corrections; and any other parties that may be involved with the family including persons chosen by the family such as friends, family members, advocates, etc. Assistance with accessing other community resources or other resources within the community mental health center, such as substance abuse counseling, is also accomplished under the broad spectrum of children's service provision. See Criterion 1 for further description of children services.

The State of South Dakota has eleven community mental health centers that the Division of Mental Health contracts with to provide mental health services in our communities. Each mental health center has an assigned catchment area, broken out by county, for which they are responsible. (See Attachment 2)

Criterion 4: Targeted Services to Rural and Homeless Populations

The barriers faced in mental health service provision in the rural areas of the state are numerous and difficult to overcome. Several community mental health centers include vast land areas, which are sparsely populated. Three Rivers Mental Health and Chemical Dependency Center located in the northwestern portion of the State and Southern Plains Behavioral Health Services located in the south central South Dakota face unique challenges in the delivery of mental health services due to the rural nature of counties in their catchment areas. Lack of transportation, high travel time for service providers, lack of appropriate housing and employment opportunities, and lack of financial resources to afford medications and basic necessities of daily life are some of the challenges faced by providers. The lack of psychiatric services in rural and frontier areas of the State also poses significant challenges in providing a broad continuum of care.

The Division of Mental Health recognizes the obstacles to effective service delivery in rural and frontier areas. The division also recognizes that community mental health centers serving rural and frontier areas often struggle financially as their localities lack the population base to support services. In addition, travel time is not billable for CARE services despite the fact that case mangers may have to travel for hours to provide home/community-based services. Beginning in FY00, the Division of Mental Health added a rural rate to SED and CARE services billable for services provided at a distance of at least 20 miles from a main or satellite office. This rate is 20% higher than the "regular" rate and allows better access to the funding allocated to community mental health centers. In FY02, the Division of Mental Health began allowing the SED and CARE rate for Three Rivers Mental Health and Chemical Dependency and Southern Plains Behavioral Health Services to be billed entirely as rural. This adaptation has allowed for service delivery that better serves the needs of the population in these areas.

In addition to establishing the rural rate, the Division of Mental Health has also explored the feasibility of using telemedicine to address the shortage of psychiatric services across the state, especially in rural and frontier areas. In FY02, a budget increase in mental health block grant funding was targeted to support telepsychiatry services. This funding allowed Southern Plains Behavioral Health Center to implement a telepsychiatry pilot program, which provided needed psychiatric services to adults with SPMI and/or children with SED. The Division of Mental Health has monitored data from this pilot to determine the efficacy of telepsychiatry services. The Division of Mental Health also continued actively advocating for Medicaid reimbursement for telepsychiatry services. In March of 2004, pharmacological management provided by physicians became reimbursable by Medicaid when provided via telemedicine.

General housing issues are of concern in South Dakota, including those individuals with SED and SPMI who are homeless or at imminent risk of becoming homeless. According to Section 304® of the Public Health Service Act, a "homeless individual" is defined as an individual who lacks housing (without regard to whether the individual is a member of a family) including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. The number of individuals who are homeless and have mental illness in South Dakota is 2,603. Services provided to

individuals who are homeless or at imminent risk of becoming homeless through the Projects for Assistance in Transition from Homelessness (PATH) include:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation services
- Staff training
- Case management
- Supportive and supervisory services in residential settings
- Referrals for primary health services
- Education services and relevant housing services
- Minor renovation
- Expansion and repair of housing
- Planning of housing
- Technical assistance in applying for housing assistance
- Improving the coordination of housing services
- Assistance with security deposits
- One-time rental assistance to prevent eviction
- Job training

All community mental health centers receive a portion of PATH funding to assist individuals who are in need of the services available through PATH. However, the bulk of PATH funding has been allocated to the two community mental health centers located in the more urban areas of Sioux Falls and Rapid City. Due to the larger population base and more metropolitan area of these cities, there is a higher percentage of homelessness, and therefore a greater need for PATH funding.

In addition to PATH funding, all community mental health centers provide assistance in locating and maintaining suitable living environments to individuals with severe and persistent mental illness. An important aspect of these services is the collaboration with the local and state housing authorities. Many of the housing facilitators and outreach workers serve as a liaison to the local housing authorities and community homeless coalitions.

During FY02, the Division of Mental Health hosted a PATH TA training "Implementing Interventions for Individuals with Co-Occurring Mental Health and Substance Use Disorders." This training was designed to assist providers in understanding co-occurring disorders and systems integration, particularly related to homeless individuals. During FY03, the Division of Mental Health hosted a second PATH TA training via teleconference. This training addressed collaborative relationships between mental health and substance abuse agencies. Training on co-occurring mental health and substance abuse disorders and the need for systems integration, formal cross-training/cross-staffing, and effective treatment models were discussed. The training also focused on housing needs including the need to expand adequate housing opportunities and implement sufficient levels of supportive services to keep individuals housed.
The Division of Mental Health is acutely aware of the shortage of housing opportunities in the state for consumers and understands that this is an essential component of allowing

individuals to remain in or return to their home communities. In FY03, The Division of Mental Health participated in the State's delegation to SAMHSA's Policy Academy on Chronic Homelessness. One of the objectives coming out of the Policy Academy was for South Dakota to develop an interagency council on homelessness. The Division of Mental Health in collaboration with South Dakota Housing Development Authority, community action agencies, shelters, domestic violence shelters, community mental health centers, consumers, etc. established a Statewide Continuum of Care. *The Housing for the Homeless Consortium* has laid the groundwork for ending chronic homelessness and designing an integrated system that will provide seamless services to individuals and families experiencing homelessness. This group of public and private organizations has been meeting monthly for approximately three and a half years to coordinate this effort. The Division of Mental Health State's PATH Contact has participated in all National PATH Teleconferences dealing with the SuperNOFA application and has shared technical assistance information with the Statewide Continuum of Care Network. The Housing for the Homeless Consortium meets on a monthly basis. The Division of Mental Health is represented on the Planning and Advisory Committee (PAC) which advises the Consortium in the direction it believes the organization should move and develops the criteria used to assess and prioritize the housing proposals to be funded through HUD (Housing and Urban Development). The Division will continue to be a part of this effort and will also encourage PATH providers to become involved. South Dakota is in the process of completing its fourth year application that is due on July 15, 2004.

Criterion 5: Management Systems

Targeted amounts in the FY05 budget specifically for children with serious emotional disturbances are $6,225,538. Funding includes Medicaid, block grant, and state general funds. Included in this budget are services provided through the SED program as well as the Indigent Medication program. The entire community-based budget is $21,432,326 and includes services to individuals with SPMI, SED, as well as other services such as outpatient, emergency, protection and advocacy, and the indigent medication program. Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council at their quarterly meetings.

Medicaid is a vital funding component of South Dakota's system of mental health care. On July 1, 1995 the Mental Health Rehabilitative Services Option was added to the Medicaid State Plan. Community mental health center services, previously restricted under the Clinic Option, became much more flexible under the Rehabilitation Option. This transition allowed service provision outside the clinic setting and provided a significant enhancement of service capability, especially in rural communities where transportation options are limited or non-existent. The Rehabilitation Option also allowed the implementation of community-based services, which are more accessible and responsive to individual consumers.

The State of South Dakota provides medical and mental health services to a large number of children eligible for Medicaid. The Department of Social Services' (DSS) budget includes a federally mandated State general fund match to federal Medicaid dollars to provide medical services to children that are Medicaid eligible. In an agreement established through a memorandum of understanding with DSS, the DMH budget includes a federally mandated State general fund match to federal Medicaid dollars to provide mental health services to children that are Medicaid eligible. Through funding provided by the recently created State Children's Health Insurance Program (CHIP), South Dakota's Medicaid program has expanded to cover all children under 19 whose families' incomes are at or below 140% of the federal poverty level. This program began July 1, 1998. It was initially targeted to families at or below 133% of federal poverty level. The eligibility cutoff was increased to the current 140% on July 1, 1999 following the 1999 Legislative Session. In addition, CHIP-NM has been created to allow families, who are not eligible for Medicaid or CHIP and whose incomes are at or below 200% of federal poverty level, to qualify. Each CMHC has made it a priority to educate families on the eligibility criteria and application process for CHIP, as well as the overall advantages to being involved in the program. The Division of Mental Health also participated in the Covering Kids and Families Initiative, a national program of the Robert Wood Johnson Foundation. This coalition included statewide collaboration of different agencies working to increase health care access for low income, uninsured children.

Children's SED services are funded through a fee for service paid for billable fifteen minute units of service. For SFY00 a 20% increase was made in the unit rate for services provided 20 miles from a main or itinerant office. Although no additional dollars were

allocated for this change, the "rural rate" will enhance access to funding to centers in rural and frontier areas with higher expenses due to travel time and non-billable staff time. In SFY02, Three Rivers Mental Health Center in Lemmon and Southern Plains Behavioral Health Services in Winner will use the rural rate for all mental health services delivered to adults with SPMI and children with SED, due to their entire catchment areas being in frontier areas of the state.

The Division of Mental Health participated in a Financial Work Group to determine if the current rate in the provision of services met the needs of the Community Mental Health Centers. The Division, in conjunction with the Financial Work Group, made increases in the SED program rates for FY05. The SED individual rate increased from $17 in FY02 to $19.75/unit for FY05.

Establishing an organized system of care requires a planning process with the involvement of consumers receiving services, family members of consumers, mental health service providers, other service providers and purchasers. The statutorily defined membership of the Mental Health Planning and Coordination Advisory Council provides a mechanism to define and prioritize needed services as well as a vehicle to collectively evaluate the system. This role is clearly defined in South Dakota Codified Law 27A-3-1.3-5, inclusive.

The Statewide Council meets quarterly to evaluate and plan services for the target populations. Committees have been established to develop specific initiatives towards better service provision. The Council is also charged with submitting a written report to the Governor by December 1st of each year. The report reflects the systems progress in implementing the State Plan.

The DMH and the Mental Health Planning and Coordination Advisory Council have worked as a team to design and develop the system of mental health services for children and adults. As a result of this partnership the following principles and values will guide the development and implementation of key features of state funded mental health services: services be client-centered and needs driven; services be home and community-based; interagency linkage; networks and resources to provide a comprehensive array of appropriate treatment and rehabilitation services; services be outcome-based, responsive and innovative; and public education and awareness to increase the understanding of mental illness.

FY2005 Proposed Intended Use Plan

Activities funded by FY2005 CMHS Block Grant will fund:

Activity	Amount
Administration	
SPMI Adult Mental Health Services	
SED Children's Mental Health Services	
Total	

Community mental health centers which will receive FY2005 Block Grant funds and projected amounts:

Community Mental Health Center	Adult SPMI	Children's SED	Total
Behavior Management Systems			
Capital Area Counseling			
Community Counseling Services			
Dakota Counseling Institute			
East Central Mental Heath Center			
Human Service Agency			
Lewis & Clark Behavioral Health Services			
Northeastern Mental Health Center			
Southeastern Behavioral HealthCare			
Southern Plains Behavioral Health Services			
Three Rivers Mental Health Center			

FY2006 Proposed Intended Use Plan

Activities funded by FY2006 CMHS Block Grant will fund:

Activity	Amount
Administration	
SPMI Adult Mental Health Services	
SED Children's Mental Health Services	
Total	

Community mental health centers which will receive FY2006 Block Grant funds and projected amounts:

Community Mental Health Center	Adult SPMI	Children's SED	Total
Behavior Management Systems			
Capital Area Counseling			
Community Counseling Services			
Dakota Counseling Institute			
East Central Mental Heath Center			
Human Service Agency			
Lewis & Clark Behavioral Health Services			
Northeastern Mental Health Center			
Southeastern Behavioral HealthCare			
Southern Plains Behavioral Health Services			
Three Rivers Mental Health Center			

FY2007 Proposed Intended Use Plan

Activities funded by FY2007 CMHS Block Grant will fund:

Activity	Amount
Administration	
SPMI Adult Mental Health Services	
SED Children's Mental Health Services	
Total	

Community mental health centers which will receive FY2007 Block Grant funds and projected amounts:

Community Mental Health Center	Adult SPMI	Children's SED	Total
Behavior Management Systems			
Capital Area Counseling			
Community Counseling Services			
Dakota Counseling Institute			
East Central Mental Heath Center			
Human Service Agency			
Lewis & Clark Behavioral Health Services			
Northeastern Mental Health Center			
Southeastern Behavioral HealthCare			
Southern Plains Behavioral Health Services			
Three Rivers Mental Health Center			

Section III: Performance Goals and Action Plans to Improve the Service System – Adult Plan

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The implementation of a comprehensive, organized, community-based system of services is a key strategy in reducing psychiatric hospitalizations within the state of South Dakota. The Division of Mental Health and the Human Services Center, the State psychiatric hospital are collaborating to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup comprised of individuals from the Division of Mental Health, the Human Services Center, and the community mental health center system was created to work on streamlining the discharge planning process to ensure that all individuals, once discharged from the State hospital, are aware of and have immediate access to mental health services in the community. To date, the group has developed a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented. This group will continue to meet to address any further areas of concern regarding discharge planning.

The Division of Mental Health, in collaboration with the Mental Health Planning and Coordination Advisory Council, has identified needs and priorities for the community mental health system for the next three years. Transformation of the system to be more consumer driven; implementation of fidelity to evidence-based practices; increased individualization of plans of care; and development of performance measures around outcomes are all goals developed during strategic planning. The Division and the Advisory Council will work closely together to ensure all areas identified as priorities will be incorporated into goals included in the State Plan. (See Section II: The Future for more detailed information)

The Division of Mental Health funds evidence-based practices across the state. The Division of Mental Health and the Division of Alcohol and Drug Abuse have a cooperative agreement regarding a residential program to treat individuals with co-occurring disorders through one community mental health center. The Serenity Hills Program is a custodial care facility for adults who are diagnosed with both mental health and substance abuse disorders. It uses a multidisciplinary "integrated" model that combines both mental health and substance abuse treatment within a single, unified and comprehensive custodial care program. The services are seamless, with a consistent approach, philosophy and set of recommendations for services. The goal of the Serenity Hills Program is for individuals to recover from both mental illness and substance abuse.

The Division of Mental Health also funds 4 IMPACT programs across the State. The IMPACT Program is a comprehensive program for providing medically related

treatment, rehabilitative, and support services to eligible consumers through a self-contained program of clinicians grouped together as a continuous treatment team. These services are provided to assist the consumer with SPMI in coping with the symptoms of their illness, minimizing the effects of their illness, and maximizing their capacity for independent living, and minimizing periods of psychiatric hospital treatment. The IMPACT Program is based on the ACT model and is intended to serve consumers who have historically failed in community settings and who have had frequent hospitalizations.

ACT and Integrated Treatment are the only two evidence-based practices that are utilized within the State. The Division of Mental Health will be working closely with the Mental Health Planning and Coordination Advisory Council and community mental health centers on development of additional evidence based practices within South Dakota. At this time though, the Division does not have the ability to set target dates or develop performance indicators for when those evidence-based practices will be available Statewide. This is for a couple of reasons: 1) Fidelity to baseline for current services that may be considered evidence based has not been developed; 2) Providing additional evidence-based practices will require additional funding sources in order to implement, and 3) Training and technical assistance, along with development of fidelity for any new evidence based practices will need to be developed. The Division will be working throughout the three years of the State Plan in this area, and explore the possibilities of modifying the State Plan within those three years, if the evidence-based practice becomes a staple service offered within the State. In the meantime, the Division of Mental Health will develop performance indicators and outcome measures around the current evidence based practices, which include ACT services and Serenity Hills, South Dakota's residential program for integrated treatment of co-occurring disorders.

On an annual basis the Division of Mental Health conducts the MHSIP Surveys for adults, children and families of children. WICHE (Western Interstate Commission for Higher Education) conducts the data analysis on all of the surveys. The Division of Mental Health has conducted both the Adult and Youth MHSIP Surveys for 5 years. The Family of Child MHSIP Survey has been conducted since 2003. The analyses of these surveys contain valuable information regarding quality, appropriateness and outcome of services for individuals within the public mental health system. This information will allow the Division of Mental Health to take a closer look at system needs/issues and address goals identified in the strategic planning process—specifically the goals around the system being consumer driven and individualized plans of care being developed.

Name of Performance Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 30 days. Reduced Utilization of Psychiatric Inpatient Beds

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	7.4%	9%	8.0%	8.0%	8.0%
Numerator	99				
Denominator	1,759				

Goal
To significantly reduce the inpatient census of the State operated mental health facility by placing all eligible individuals with mental illness appropriately in the community.

Target
Reduction in inpatient census of the State operated mental health facility by another fifteen individuals from the current level.

Population
Adults with severe and persistent mental illness.

Brief Name
30 day inpatient readmission rate

Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 30 days.

Measure
Numerator: Number of persons, aged 18+, who are readmitted to HSC within 30 days.
Denominator: Number of person, aged 18+, discharged from HSC during the past year.

Source(s) of Information
DMH and HSC information systems.

Special Issues
The number of re-admissions is comprised of a duplicate count (i.e., an adult readmitted repeatedly would be counted at each readmission.)

The Division of Mental Health will continue to look towards opportunities for increasing funding and staff of community mental health centers to assist in reducing the number of hospitalizations of individuals with SPMI.

The Division did not have this as a goal in the previous State Plan. Therefore, no numbers were projected for SFY04. The Division of Mental Health will make projections for future years of this State Plan.

Significance
A major outcome of the development of a community-based system of care will be accomplished through reduced utilization of state psychiatric inpatient beds.

Name of Performance Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 180 days. Reduced Utilization of Psychiatric Inpatient Beds

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	7.8%	NA	6.8%	6.0%	5.2%
Numerator	137	NA	119	104	89
Denominator	1,759	NA	1,744	1,729	1,714

Goal
To significantly reduce the inpatient census of the State operated mental health facility by placing all eligible individuals with mental illness appropriately in the community.

Target
Reduction in inpatient census of the State operated mental health facility by another fifteen individuals from the current level.

Population
Adults with severe and persistent mental illness.

Brief Name
180 day inpatient readmission rate
Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 180 days.

Measure
Numerator: Number of persons, aged 18+, who are readmitted to HSC within 180 days.
Denominator: Number of person, aged 18+, discharged from HSC during the past year.

Source(s) of Information
DMH and HSC information systems.

Special Issues
The number of re-admissions is comprised of a duplicate count (i.e., an adult readmitted repeatedly would be counted at each readmission.)

The Division of Mental Health will continue to look towards opportunities for increasing funding and staff of community mental health centers to assist in reducing the number of hospitalizations of individuals with SPMI.

The Division did not have this as a goal in the previous State Plan. Therefore, no numbers were projected for SFY04. The Division of Mental Health will make projections for future years of this State Plan.

Significance
A major outcome of the development of a community-based system of care will be accomplished through reduced utilization of state psychiatric inpatient beds.

Name of Performance Indicator
Number of persons with SPMI receiving evidence-based practices through ACT.
Evidence-based practices

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	205	215	225	235	245

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Increase the number of individuals receiving ACT by 10 individuals over the current level.

Population
Adults with severe and persistent mental illness.
Criterion
Comprehensive community-based mental health service system.

Brief Name
Number receiving IMPACT Services.

Indicator
Number of persons with SPMI receiving IMPACT Services.

Source(s) of Information
DMH reporting system.

Special Issues
The Division of Mental Health, along with IMPACT Programs have identified individuals who require the intense services that IMPACT provides. These individuals have failed numerous times in other community placements, and have had frequent psychiatric hospitalizations. The Division of Mental Health and the IMPACT Programs will continue to work closely together to assure there is a baseline fidelity to the evidence based ACT model, along with ensuring that services provided through IMPACT are outcome driven.

Over the three year grant period, the Division will continue to explore opportunities for increasing this evidence based practice statewide.

The Division did not have this as a goal in the previous State Plan. Therefore, no numbers were projected for SFY04. The Division of Mental Health will make projections for future years of this State Plan.

Significance
The Division of Mental Health believes that IMPACT is a very important service to offer to adult consumers who have failed in less intensive services. Providing appropriate mental health services to these adults is a priority of the DMH and the mental health block grant legislation.

Name of Performance Indicator
Number of persons with SPMI receiving evidence-based practice of Integrated Treatment. Evidence-based practices

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	54	62	62	62	62

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Maintain the number of individuals receiving integrated treatment through Serenity Hills.

Population
Adults with severe and persistent mental illness.

Brief Name
Number receiving integrated treatment through Serenity Hills.

Indicator
Number of persons with SPMI receiving Serenity Hills Services.

Measure
Numerator: Number of SPMI adults, aged 18+, who are receiving services through Serenity Hills.
Denominator: None.

Source(s) of Information
DMH reporting system.

Special Issues
The Division of Mental Health and the Division of Alcohol and Drug Abuse have a cooperative agreement regarding Serenity Hills. Serenity Hills is a custodial care facility providing services to adults with a co-occurring disorder. Alcohol/Drug services and mental health services are integrated in a multidisciplinary model. The services are seamless, with a consistent approach and philosophy.

The Division of Mental Health plays an important role in development of co-occurring disorder services within the State. The Department of Human Services, which houses both the Division of Alcohol and Drug Abuse and the Division of Mental Health supports integrated treatment development through participation in the Policy Academy team on Co-Occurring Disorders (see Attachment10 for Strategic Plan).

Although the Division is currently looking at maintenance, through involvement with the Policy Academy, the Division of Mental Health will continue to explore increasing availability of integrated treatment to communities statewide. The Division will continue to look at this area over the entire three year grant period.

Significance
Assuring access to mental health and chemical dependency services is of primary importance due to the increasing numbers of individuals diagnosed with co-occurring disorders.

Name of Performance Indicator
Number of consumers reporting positively about outcomes. Client Perception of Care

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	58%	NA	63%	68%	73%
Numerator	203	NA	227	252	277
Denominator	350	NA	360	370	380

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Increase in the number of people reporting positively about outcomes by 5%.

Population
Adults with severe and persistent mental illness.

Brief Name
Number reporting positively on outcomes.

Indicator
Number of consumers reporting positively about outcomes

Measure
Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.
Denominator: Total responses reported in the outcome domain on the adult consumer survey.

Source(s) of Information
MHSIP adult consumer surveys

Special Issues

This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. 8 questions are analyzed in determining positive reporting of outcomes by consumers. Individuals filling out the survey must check "strongly agree" or "agree to the following statements:

- *I deal more effectively with daily problems*
- *I am better able to control my life*
- *I am better able to deal with crisis*
- *I am getting along better with my family*
- *I do better in social situations*
- *I do better in school and/or work*
- *My symptoms are not bothering me as much*
- *My housing situation has improved*

The Division of Mental Health did not have this as a performance indicator in prior years. Therefore, no projected numbers for 2004 have been developed. However, the Division of Mental Health will provide projected numbers for all three years of this State Plan.

Significance
The Division of Mental Health feels this is important in assuring that quality mental health services are being provided across the State and allowing an increase in functioning for adult consumers receiving mental health services.

Name of Performance Indicator
Percentage of consumers receiving CMHC services who report they are working

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	41%	41.4%	46%	51%	56%
Numerator	141	148	169	192	217
Denominator	347	357	367	377	387

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Increase in the number of consumers who reporting they are working by 5%.

Population
Adults with severe and persistent mental illness.

Brief Name
Percentage reporting they are working.

Indicator
Percentage of consumers receiving CMHC services who report they are working.

Measure
Numerator: Number of consumers surveyed with SPMI receiving CMHC services who report they are working—"yes" response to one of the three following statements: "I am working for money in the community, I am doing volunteer activity, I am employed in the mental health center."
Denominator: Total number of responses reported on the statements above.

Source(s) of Information
MHSIP adult consumer surveys.

Significance
The Division of Mental Health feels this is important in assuring that quality mental health services are being provided across the State and allowing an increase in employment opportunities for adult consumers receiving mental health services.

Name of Performance Indicator
Percentage of consumers receiving CMHC services who report participation in treatment planning

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	59%	62%	72%	85%	100%
Numerator	203	221	264	320	386
Denominator	346	356	366	376	386

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Increase in the number of consumers who reporting they are participating in treatment planning by 13% in 2005-2006 and 15% in 2007.

Brief Name
Percentage participating in treatment planning.

Indicator
Percentage of consumers receiving CMHC services who report participation in treatment planning

Measure
Numerator: Number of consumers surveyed with SPMI receiving CMHC services who report they are participating in treatment planning (positive responses— agree or strongly agree— to statement 29 "I, not staff, have decided my treatment goals."
Denominator: Total responses reported to statement 29 on the adult consumer survey.

Source(s) of Information
MHSIP adult consumer surveys.

Significance
Assuring that adults who require mental health services actively participate in their treatment is a priority of the DMH.

Name of Performance Indicator
Percentage of consumers receiving CMHC services who report increased levels of functioning

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	81%	82%	83%	84%	85%
Numerator	265	277	289	301	313
Denominator	328	338	348	358	368

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Increase in the number of individuals reporting increased levels of functioning by 1%.

Population
Adults with severe and persistent mental illness.

Brief Name
Percentage reporting increased level of functioning.

Indicator
Percentage of consumers receiving CMHC services who report increased levels of functioning

Measure
Numerator: Number of consumers surveyed with SPMI receiving CMHC services who report increased levels of functioning— agree or strongly agree— to two out of three of the following statements: "I do better in school and/or work, I am better able to control my life, and I can more effectively deal with daily problems."
Denominator: Total number of responses reported on the statements above.

Source(s) of Information
MHSIP adult consumer surveys.

Significance
The Division of Mental Health feels this is important in assuring that quality mental health services are being provided across the State and allowing an increase in functioning for adult consumers receiving mental health services.

Name of Performance Indicator
Percentage of consumers receiving CMHC services who report living independently

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	86%	87%	88%	89%	90%
Numerator	298	311	323	336	348
Denominator	347	357	367	377	387

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Increase in the number of consumers who reporting living independently by 1% above current level.

Population
Adults with severe and persistent mental illness.

Brief Name
Percentage reporting living independently.

Indicator
Percentage of consumers receiving CMHC services who report living independently.

Measure
Numerator: Number of consumers surveyed with SPMI receiving CMHC services who report they are living independently—total number of "house, apartment, mobile home" responses to the following statement: "I am currently living in a."
Denominator: Total number of responses reported on the statement above.

Source(s) of Information
MHSIP adult consumer surveys.

Significance
Assuring that quality mental health services are provided in order to increase functioning is a priority of the DMH.

Name of Performance Indicator
Percentage of consumers receiving CMHC services who report involvement in the criminal justice system during the last year

Population
Adult SPMI

Criterion
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	23%	22%	21%	20%	19%
Numerator	80	77	76	74	72
Denominator	341	351	361	371	381

Goal
Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target
Decrease in the number of consumers who report involvement with the criminal justice system by 1% below current level.

Population
Adults with severe and persistent mental illness.

Brief Name
Percentage reporting involvement in the criminal justice system.

Indicator
Percentage of consumers receiving CMHC services who report involvement in the criminal justice system during the last year.

Measure
Numerator: Number of consumers surveyed with SPMI receiving CMHC services who report "yes" to one (or both) of the following statements: "In the past 12 months I have been arrested by the police" and/or "In the past 12 months I have gone to court for something I did."
Denominator: Number of total responses to the statements above.

Source(s) of Information
MHSIP adult consumer surveys.

Significance
Assuring that quality mental health services are provided in order to increase functioning is a priority of the DMH

Criterion 2: Mental Health System Data Epidemiology

The Division of Mental Health provides mental health services to adults (age 18 and older) with severe and persistent mental illness, as indicated by at least (1) of the following:

- Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime.
- Has experienced a single episode of psychiatric hospitalization with an Axis I and/or Axis II diagnosis per the DSM-III-R or DSM-IV.
- Has been maintained with psychotropic medication for at least one year.
- Has frequent crisis contacts with a community mental health center for more than six months as a result of severe and persistent psychiatric symptomatology.

In addition to having a severe mental disability, the individual must have impaired role functioning as indicated by at least three (3) of the following:

- Is unemployed or has markedly limited job skills and/or poor work history.
- Is unable to perform basic living skills without assistance.
- Exhibits inappropriate social behavior that results in concern by the community and/or request for mental health services by the judicial/legal systems.
- Is unable to procure appropriate public support services without assistance.
- Requires public financial assistance for out of hospital maintenance.
- Lacks social support systems in a natural environment.

Based on the WICHE MH Estimation Project, estimates of need for mental heatlh services for South Dakotans with severe and persistent mental illness is projected at 19,229. Over the next three years, the Division of Mental Health will continue to monitor closely the numbers of individuals served statewide, and look to increase numbers served through better access to service, and exploration of additional areas of funding for services to the target population of adults with severe and persistent mental illness.

Name of Performance Indicator
Number of persons with SPMI Increased Access to Services

Population
Adult SPMI

Criterion
Mental Health System Data Epidemiology

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	16.8%	16.9%	17%	17.1%	17.2%
Numerator	3,246	3,276	3,306	3,336	3,366
Denominator	19,229	19,325	19,422	19,519	19,617

Goal
Ensure all individuals statewide have access to appropriate mental health services.

Target
Increase number of individuals served by 30 above current level.

Population
Adults with severe and persistent mental illness.

Brief Name
Number of adults served.

Indicator
Percentage of adults with SPMI served.

Measure
Numerator: Numbers of SPMI adults (over the age of 18).
Denominator: Estimated number of adults with SPMI.

Source(s) of Information
Numerator: DMH MIS, WICHE Estimation of MH Need, WICHE Mental Health Program http://psy.utmb.edu.

Special Issues
The DMH relies on a data collection system (MIS) to provide client information and process billing. The current MIS is antiquated, limiting system updates and information queries. System capacity to provide unduplicated counts of individuals receiving services is limited. State totals provided contain duplicated counts of individuals served by more than one community mental health center. Individuals served by more than one community mental health center would be counted by each center providing services. The Division of Mental Health, through the Data Infrastructure Grant, is now developing a new MIS system which will allow reporting on unduplicated counts of individuals served. The Division is looking toward SFY05 for implementation of the new management information system.

The MIS is interfaced with the Department of Social Services' Medicaid data collection system (MMIS) which has expansive capabilities specific to Medicaid eligible

consumers. The DMH and the Department of Social Services work closely to ensure the two MIS systems are compatible and HIPAA compliant.

Prevalence data from WICHE was used rather than the information provided in the Federal Register. WICHE's data provided prevalence estimates by county, based on the demographics of each county. This breakdown provides more accurate prevalence rates for each catchment area. The information provided in the Federal Register only provided a state total of prevalence data.

The WICHE data was computed based on census information from 2000. This data assumes the growth in the number of adults with SPMI is at the same rate as the total population.

Significance

Assuring access to mental health services for individuals suffering from a severe and persistent mental illness is a priority of the Division of Mental Health and the mental health block grant legislation.

Criterion 4: Targeted Services to Rural and Homeless Populations

South Dakota is predominantly a frontier State with 66 counties and 76,536 square miles. Nine Indian Nations are spread throughout the state and encompass 15,000 square miles. 754,844 people make up the total population of South Dakota. 8.3% of the total population is Native American and 88.7% is white. Thirty-four of the state's counties are classified as frontier (less than 6 persons per square mile) and 31 are classified as rural (6 to 99 persons per square mile). Minnehaha County in the southeastern part of the state is considered the only urban (100 or more persons per square mile).

The barriers faced in mental health service provision in the rural areas of the state are numerous and difficult to overcome. Three Rivers Mental Health and Chemical Dependency Center, in the northwest portion of the state covers the counties of Corson, Dewey, Harding, Mead, Perkins and Ziebach. This also includes areas of the Standing Rock and Cheyenne River Sioux Nations. Southern Plains Behavioral Health Services in the south central region of South Dakota covers the counties of Gregory, Mellette, Todd and Tripp. The Rosebud Sioux Nation is also included in this area. The rural nature of each of these service areas poses some unique challenges in delivery of mental health services. Lack of transportation, high travel time for service providers, lack of appropriate housing and employment opportunities, lack of financial resources to afford medications and basic necessities of daily life, and resistance to traditional mental health services are major issues that will need to be addressed. Psychiatry services in the rural and frontier areas of the state pos a significant challenge to providing a broad continuum of care. Often times psychiatrists are not willing to live and work in these rural and frontier areas, and contracting with those who are willing is not cost effective for the mental health service providers.

According to Section 340® of the Public Health Service Act, a "homeless" individual is defined as an individual with SPMI or SED who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

PATH funds are allocated to all community mental health centers throughout South Dakota. The allocation amounts are based on the need for services. The more urban areas of Sioux Falls and Rapid City have the largest homeless populations; therefore, the need for funding to address the issue of homeless is greatest in these locations. Although smaller numbers are seen in other areas of the state, homelessness remains an issue statewide. Due to this, a smaller amount of funding has been allocated to each of the remaining community mental health centers.

South Dakota's community mental health centers provide services through the CARE program to individuals with severe and persistent mental illness. The children's SED program provides services to children with serious emotional disturbance. The primary goal of PATH is the identification and provision of services to individuals with a severe mental illness and/or dually-diagnosed and children with serious emotional disturbance

and their families, who are homeless, and who have not previously been served or served successfully by community mental health centers.

Additionally, consumers who are unable or unwilling to access existing services will be considered eligible for PATH-funded services. This will result in the availability of comprehensive services that are responsive to individual needs and circumstances.

It is assumed that many of the individuals eligible for services under PATH have historically not linked with the community mental health center system or have received limited services due to sporadic utilization. The ability to provide services in a variety of locations and to consumers who are not tied to a specific funding source should assist individuals in accessing the necessary supports in a less intrusive, more comfortable fashion. An additional benefit is the flexibility for staff to monitor consumer status in a non-clinical setting.

Name of Performance Indicator
Number of adults who are homeless, or at risk of homelessness, receiving PATH housing funds

Population
Adult SPMI

Criterion
Targeted Services to Rural and Homeless Populations

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	39.5%	39.6%	39.7%	39.8%	39.9%
Numerator	1,027	1,031	1,033	1,036	1,039
Denominator	2,603	2,603	2,603	2,603	2,603

Goal
Provide comprehensive mental health services to homeless and rural populations of adults with SPMI.

Target
Increase number of homeless individuals served through PATH by .1% above current level.

Population
Adults with severe and persistent mental illness.

Brief Name
Number receiving PATH.

Indicator
Number of adults who are homeless, or at risk of homelessness, receiving PATH housing funds.

Measure
Numerator: Numbers adults with SPMI who are homeless, or at risk of homelessness, and who receive PATH housing funds during the SFY.
Denominator: Estimated number of adults who are homeless.

Source(s) of Information
PATH quarterly reports submitted by CMHCs, and the 1999 Quantitative Assessment of Estimated Number of Homeless Adults, Children and Youth in South Dakota.

Significance
Assuring that PATH resources are being provided appropriately and according to the needs of individuals in the target population is a primary goal of the mental health block grant law and a contingency of PATH funding. The number served includes individuals that were provided outreach or contact, but not necessarily enrolled in PATH Programs.

Name of Performance Indicator
Number of adults receiving services in catchment areas that are predominately frontier

Population
Adult SPMI

Criterion
Targeted Services to Rural and Homeless Populations

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator					
Numerator					
Denominator					

Goal
Provide comprehensive mental health services to homeless and rural populations of adults with SPMI.

Target
Increase access to services in rural states by providing services to an additional 15 people in the rural/frontier areas of the state.

Population
Adults with severe and persistent mental illness.

Brief Name
Number receiving services in frontier areas.

Indicator
Number of adults receiving services in catchment areas that are predominately frontier.

Measure
Numerator: Numbers of adults with SPMI who receive services in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Center.
Denominator: Estimated prevalence of adults with SPMI in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Center.

Source(s) of Information
Numerator: DMH information system.
Denominator: Western States Resource Book: State Mental Health Authority Survey and Needs Assessment—WICHE Estimation Project (http://psy.utmb.edu/estimation/index_htm/South%20Dakota.htm)

Special Issues
Prevalence data estimates that the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services have the lowest rate of CARE services provided. When considering causal factors, the demographics of each county within these catchment areas provide insight into the combination of barriers to be overcome. Consider (1) population per square mile (2) percentage of Native Americans (3) percentage living under 100% of the federal poverty level.

TRMHC	***(1)***	***(2)***	***(3)***
Corson	1.7	48.5%	42.5%
Dewey	2.4	66.6%	44.4%
Perkins	1.4	1.4%	15.2%
Ziebach	1.1	64.0%	51.1%

SPBHS	***(1)***	***(2)***	***(3)***
Gregory	5.3	5.3%	21.6%
Mellette	1.6	46.7%	41.3%
Todd	6.0	82.4%	50.2%
Tripp	4.3	9.7%	20.6%

This data compares to Statewide averages of 9.2 persons per square mile, 8.3% Native American, and 15.9% under 100% of the federal poverty guidelines.

Shannon County also has a high concentration of Native Americans and a significant population living under 100% of the federal poverty level (respectively 94.7% and 63.1%). Shannon County falls into the Behavior Management Systems catchment area. Although prevalence data may be broken down by catchment area, the current MIS data system prevents us from reporting this information by county.

Significance: Three Rivers Mental Health Center and Southern Plains Behavioral Health Services provide services in the most rural areas of South Dakota. These agencies also serve three of four of the State's largest Indian Reservations. Assuring access to mental health services for adults suffering from SPMI is a primary goal of the mental health block grant legislation. The provision of services to rural areas and targeted populations is also indicative of this goal.

Criterion 5: Management Systems

Targeted amounts in the FY05 budget specifically for services for adults with severe and persistent mental illness is $11,517,121 which includes Medicaid, block grant, and state general funds. The budget includes services provided through the CARE and IMPACT Programs, Serenity Hills, and residential (room and board) for targeted populations. The entire community-based budget is $21,432,326 and includes services to individuals with SPMI, SED, as well as other services such as outpatient, emergency, protection and advocacy, and the indigent medication program. Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council at their quarterly meetings.

The State of South Dakota provides medical and mental health services to a large number of individuals eligible for Medicaid. The Department of Social Services' (DSS) budget includes a federally mandated State general fund match to federal Medicaid dollars to provide medical services to individuals that are Medicaid eligible. Established through a memorandum of understanding with DSS, the DMH budget includes a federally mandated, State general fund match to federal Medicaid dollars to provide mental health services to individuals that are Medicaid eligible.

CARE and IMPACT services are funded through a day rate paid for a billable service provided for a minimum of fifteen minutes. In SFY2000, a 20% increase was made in the daily rate for services provided 20 miles from a main or itinerant office. Although no additional dollars were allocated for this change, the "rural rate" will enhance access to funding to centers in rural and frontier areas with higher expenses due to travel time and non-billable staff time. In SFY02, Three Rivers Mental Health Center in Lemmon and Southern Plains Behavioral Health Services in Winner began using the rural rate for all mental health services delivered to adults with SPMI, due to their entire catchment areas being in frontier areas of the State. Also in SFY02, the Division of Mental Health, in conjunction with the Financial Work Group, established a new rate for CARE. The Psychiatric and CNP/PA services have been cared out of the CARE rate and now are billed separately from CARE Services. The amount of funding per community mental health center is capitated by purchase of service agreements requiring centers to prioritize in determining the intensity of service needs for each individual.

Emergency services are also provided through purchase of services agreements with the eleven community mental health centers.

Current rates for services will be evaluated as part of an ongoing process over the entire three years of the State Plan. The Division of Mental Health will provide ongoing training addressing rate change issues, changes in CPT codes, and making our systems compliant with HIPAA requirements.

Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council in their quarterly meetings. The Division of Mental Health uses MIS data to monitor contract and Title XIX Expenditures.

To ensure the involuntary commitment process is being handled appropriately, the Division of Mental Health offers a Qualified Mental Health Professional Endorsement, which allows qualified individuals to perform the mental health status examination prior to the involuntary commitment of an individual. During the 2003 Legislative Session, the legislature changed the statute to allow additional professionally licensed individuals to become Qualified Mental Health Professionals (QMHPs). The professionals added were Licensed Professional Counselors or Licensed and Certified Social Workers employed by the State of South Dakota or community mental health centers and Licensed Marriage and Family Therapists (LMFTs). Prior to this change, individuals licensed as LPCs had to have the mental health designation (LPC-MH) and LMFTs did not qualify to become endorsed as QMHPs. The addition of these professionals will assist in overcoming the rural issues of the state when individuals are faced with involuntary commitment. There are now 284 individuals endorsed as QMHPs in the State of South Dakota. The Division of Mental Health will look at increasing the numbers of Qualified Mental Health Professionals statewide during the entire three years this State Plan will cover.

Name of Performance Indicator
Average amount of public funds expended on mental health services for adults with SPMI

Population
Adult SPMI

Criterion
Management Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	3,260	3,327	3,396	3,466	3,538
Numerator	10,583,505	10,901,010	11,228,040	11,564,881	11,911,828
Denominator	3,246	3,276	3,306	3,336	3,366

Goal
Ensure resources for services to adults with SPMI are allocated based on consumer need.

Target
Increase the amount of public funds expended by 3% through inflationary increases.

Population:
Adults with severe and persistent mental illness.

Brief Name:
Average resources expended per adult with SPMI.

Indicator:
Average amount of public funds expended on mental health services for adults with SPMI.

Measure:
Numerator: Total amount of direct service expenditure for adults with SPMI in SFY.
Denominator: Total number of adults with SPMI receiving services in SFY.

Source(s) of Information
DMH Management Information System.

Significance
Ensuring resources are allocated appropriately is a priority of the DMH.

Section III: Performance Goals and Action Plans to Improve the Service System – Children's Plan

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The children's SED program is an intensive and comprehensive, child-centered, family-focused, community-based, individualized system of care that delivers mental health services to children with serious emotional disturbances. The SED program provides access to a comprehensive array of services that address a child's physical, psychological, emotional, social and educational needs. The program provides children with individualized services in accordance with the unique needs and strengths of the child. These services are provided to SED children within the least restrictive, most normative environment that is clinically appropriate and in a manner that is sensitive and responsive to children's cultural differences and special needs. Parents, families, and other child-serving agencies are full participants in all aspects of the evaluation, planning, and delivery of SED services. The goal of these services is to ensure that children with SED are able to live with their families in their home communities whenever possible.

The implementation of a comprehensive, organized, community-based system of services is a key strategy in reducing psychiatric hospitalizations within the state of South Dakota. The Division of Mental Health and the Human Services Center, the State psychiatric hospital are collaborating to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup comprised of individuals from the Division of Mental Health, the Human Services Center, and the community mental health center system was created to work on streamlining the discharge planning process to ensure that all individuals, once discharged from the State hospital, are aware of and have immediate access to mental health services in the community. To date, the group has developed a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented. This group will continue to meet to address any further areas of concern regarding discharge planning.

The Division of Mental Health, in collaboration with the Mental Health Planning and Coordination Advisory Council, has identified needs and priorities for the community mental health system for the next three years. Transformation of the system to be more consumer driven; implementation of fidelity to evidence-based practices; increased individualization of plans of care; and development of performance measures around outcomes are all goals developed during strategic planning. The Division and the Advisory Council will work closely together to ensure all areas identified as priorities will be incorporated into goals included in the State Plan. (See Section II: The Future for more detailed information)

On an annual basis the Division of Mental Health conducts the MHSIP Surveys for adults, children and families of children. WICHE (Western Interstate Commission for Higher Education) conducts the data analysis on all of the surveys. The Division of Mental Health has conducted both the Adult and Youth MHSIP Surveys for 5 years. The Family of Child MHSIP Survey has been conducted since 2003. The analyses of these surveys contain valuable information regarding quality, appropriateness and outcome of services for individuals within the public mental health system. This information will allow the Division of Mental Health to take a closer look at system needs/issues and address goals identified in the strategic planning process—specifically the goals around the system being consumer driven and individualized plans of care being developed.

Name of Performance Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 30 days. Reduced Utilization of Psychiatric Inpatient Beds.

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	1	1	1	1	1
Numerator					
Denominator					

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Maintain low 30 day inpatient readmission rate.

Brief Name
30 day inpatient readmission rate

Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 30 days.

Measure
Numerator: Number of persons, under age 18, who are readmitted to HSC within 30 days.
Denominator: Number of person, under age 18, discharged from HSC during the past year.

Source(s) of Information
DMH and HSC information systems.

Special Issues
The number of re-admissions is comprised of a duplicate count (i.e., a child readmitted repeatedly would be counted at each readmission.)

Significance
Reduction in the number of children with SED in inpatient psychiatric facilities is a priority of the DMH and a primary goal of the mental health block grant legislation.

Name of Performance Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 180 days. Reduced Utilization of Psychiatric Inpatient Beds

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	2	2	2	2	2
Numerator					
Denominator					

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Maintain low 180 day inpatient readmission rate.

Brief Name
180 day inpatient readmission rate

Indicator
Decreased rate of readmissions to State Psychiatric Hospitals within 180 days.

Measure
Numerator: Number of persons, under age 18, who are readmitted to HSC within 180 days.
Denominator: Number of persons, under age 18, discharged from HSC during the past year.

Source(s) of Information
DMH and HSC information systems.

Special Issues
The number of re-admissions is comprised of a duplicate count (i.e., a child readmitted repeatedly would be counted at each readmission.)

Significance
Reduction in the number of children with SED in inpatient psychiatric facilities is a priority of the DMH and a primary goal of the mental health block grant legislation.

Name of Performance Indicator
Number of evidence-based practices provided.

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator					
Numerator					
Denominator					

Goal
N/A

Target
N/A

Brief Name
Number of evidence-based practices.

Indicator
Number of evidence-based practices provided.

Measure
Numerator: For each of eight evidence-based practices, indicate whether it is being provided.
Denominator: None.

Source(s) of Information
N/A

Special Issues
At this time no evidence based practices are being provided.

Significance
Over the three years of this State Plan, the Division of Mental Health will be looking at all evidence based practices within the state to determine fidelity, along with determining efficacy to include evidence based practices associated with children's services.

Name of Performance Indicator
Number of children with SED receiving evidence-based practices.

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator					
Numerator					
Denominator					

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
N/A

Brief Name
Number receiving evidence-based practices.

Indicator
Number of children with SED receiving evidence-based practices.

Measure
Numerator: Number of children with SED who are receiving any of the eight evidence-based practices.
Denominator: None.

Source(s) of Information
DMH reporting system.

Special Issues
At this time no evidence based practices are being provided.

Significance
Over the three years of this State Plan, the Division of Mental Health will be looking at all evidence based practices within the state to determine fidelity, along with determining efficacy to include evidence based practices associated with children's services.

Name of Performance Indicator: Number of youth reporting positively about outcomes.

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	66%	NA	71%	76%	81%
Numerator	91	NA	105	120	136
Denominator	138	NA	148	158	168

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Increase in the number of people reporting positively about outcomes by 5% each year.

Brief Name
Number reporting positively on outcomes.

Indicator
Number of consumers reporting positively about outcomes

Measure
Numerator: Number of positive responses reported in the outcome domain on the youth consumer survey.
Denominator: Total responses reported in the outcome domain on the youth consumer survey.

Source(s) of Information
MHSIP youth consumer survey

Special Issues
This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. 8 questions are analyzed in determining positive reporting of outcomes by consumers. Individuals filling out the survey must check "strongly agree" or "agree to the following statements:

- *I deal more effectively with daily problems*
- *I am better able to control my life*
- *I am better able to deal with crisis*
- *I am getting along better with my family*
- *I do better in social situations*
- *I do better in school and/or work*
- *My symptoms are not bothering me as much*
- *My housing situation has improved*

The Division of Mental Health did not have this as a performance indicator in prior years. Therefore, no projected numbers for 2004 have been developed. However, the Division of Mental Health will provide projected numbers for all three years of this State Plan.

Significance
The Division of Mental Health feels this is important in assuring that quality mental health services are being provided across the State and allowing an increase in functioning for youth consumers receiving mental health services.

Name of Performance Indicator
Percentage of youth receiving CMHC services who report participation in treatment planning.

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	76%	77.4%	84%	92%	100%
Numerator	101	106	120	141	163
Denominator	133	137	143	153	163

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Increase in the number of reporting positively about participation in treatment planning by 8% each year.

Brief Name
Percentage participating in treatment planning.

Indicator
Percentage of youth receiving CMHC services who report participation in treatment planning.

Measure
Numerator: Number of youth surveyed with SED receiving CMHC services who report they are participating in treatment planning (positive responses— agree or strongly agree— to two of four survey statements "I helped to choose me services, I helped to choose my treatment plan goals, I was actively involved in my own treatment, and I, not staff, decided my treatment goals."
Denominator: Total responses reported to the statements above.

Source(s) of Information
MHSIP youth consumer surveys.

Significance
Assuring that youth who require mental health services actively participate in their treatment is a priority of the DMH.

Name of Performance Indicator
Percentage of youth receiving CMHC services who report increased levels of functioning.

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	69%	71%	73%	75%	77%
Numerator	92	97	105	116	126
Denominator	134	137	144	154	164

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Increase in the number of reporting increased levels of functioning by 2% each year.

Brief Name
Percentage reporting increased level of functioning.

Indicator
Percentage of youth receiving CMHC services who report increased levels of functioning

Measure
Numerator: Number of youth surveyed with SED receiving CMHC services who report increased levels of functioning— agree or strongly agree— to two out of five of the following statements: "I am better at handling my daily life, I get along better with family members, I get along better with friends and other people, I am doing better in school and/or work, and I am better able to cope when things go wrong."
Denominator: Total number of responses reported on the statements above.

Source(s) of Information
MHSIP youth consumer surveys.

Significance
Assuring that children who require mental health services actively participate in their treatment is a priority of the DMH.

Name of Performance Indicator
Percentage of youth receiving CMHC services who report their families are receiving services from CMHC

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	NA	88.1%	90.1%	92.1%	94.1%
Numerator	NA	119	121	124	126
Denominator	NA	135	138	140	143

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Increase in the number of youth who report their families are receiving services by 2%.

Brief Name
Percentage reporting families are receiving services.

Indicator
Percentage of youth receiving CMHC services who report families are receiving services within the community mental health system.

Measure
Numerator: Number of youth surveyed with SED receiving CMHC services who report at least one of the following responses "outpatient therapeutic services or services to support parents" to the survey question "Please let us know which of the following services you and your family received from this center in the last 6 months.
Denominator: Total number of responses reported on the statement above.

Source(s) of Information
MHSIP youth consumer surveys.

Special Issues
This performance indicator was not measured in SFY2003, however, it has been added as a performance indicator for SFY04. The Division of Mental Health plans on providing data for this performance indicator over the three years of this State Plan.

Significance
Assuring that quality mental health services are provided in order to increase functioning is a priority of the DMH.

Name of Performance Indicator
Percentage of youth receiving CMHC services who report involvement in the juvenile justice system.

Population
Children with serious emotional disturbance.

Criterion 1
Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	22%	21%	20%	19%	18%
Numerator	31	29	28	27	26
Denominator	139	140	141	142	143

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Decrease in the number of youth who report involvement with the juvenile justice system by 1% below current level.

Brief Name
Percentage reporting involvement in the juvenile justice system.

Indicator
Percentage of youth receiving CMHC services who report involvement in the juvenile justice system.

Measure
Numerator: Number of youth surveyed with SED receiving CMHC services who report "yes" to the survey question: "Have you been in court in the last 6 months.
Denominator: Number of total responses to the statements above.

Source(s) of Information
MHSIP youth consumer surveys.

Significance
Assuring that quality mental health services are provided in order to increase functioning is a priority of the DMH.

Criterion 2: Mental Health System Data Epidemiology

The Division of Mental Health provides mental health services to children with severe emotional disturbances (SED), as indicated by

6. The individual is between 0 and 18 years of age or is between 18 and 21 years of age and needs a continuation of services that were started before the age of 18 in order to realize specific service goals or during transition to adult services; and
7. The individual exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family or peer group; and
8. The individual has a mental disorder diagnosed under DSM III-R or DSM-IV (V Codes not included); and
9. The individual demonstrates a need for one or more special care services, in addition to mental health services; and
10. The individual has problems with a demonstrated or expected longevity of at least one (1) year or has an impairment of short duration and high severity

Based on the WICHE MH Estimation Project, estimates of need for mental health services for South Dakota children with serious emotional disturbance are projected at 15,453.

Name of Performance Indicator
Number of persons with SED; Increased Access to Services

Population
Children with serious emotional disturbance.

Criterion 2
Mental Health System Data Epidemiology

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	23.6%	23.7%	23.8%	23.9%	24%
Numerator	15,453	15,530	15,608	15,685	15,764
Denominator	3,650	3,686	3,723	3,760	3,798

Goal
Ensure all individuals statewide have access to appropriate mental health services.

Target
Increase number of individuals served by 1% each year.

Brief Name: Number of children served.

Indicator: Number of children with SED served.

Measure: Numerator: Numbers of children (under 18) with SED served.
Denominator: Estimated number of children with SED.

Source(s) of Information: DMH MIS, WICHE Estimation of MH Need, WICHE Mental Health Program http://psy.utmb.edu.

Special Issues: The DMH relies on a data collection system (MIS) to provide client information and process billing. The current MIS is antiquated, limiting system updates and information queries. System capacity to provide unduplicated counts of individuals receiving services is limited. State totals provided contain duplicated counts of individuals served by more than one community mental health center. Individuals served by more than one community mental health center would be counted by each center providing services. The Division of Mental Health, through the Data Infrastructure Grant, is now developing a new MIS system which will allow reporting on unduplicated counts of individuals served. The Division is looking toward SFY05 for implementation of the new management information system.

The MIS is interfaced with the Department of Social Services' Medicaid data collection system (MMIS) which has expansive capabilities specific to Medicaid eligible consumers. The DMH and the Department of Social Services work closely to ensure the two MIS systems are compatible and HIPAA compliant.

Prevalence data from WICHE was used rather than the information provided in the Federal Register. WICHE's data provided prevalence estimates by county, based on the demographics of each county. This breakdown provides more accurate prevalence rates for each catchment area. The information provided in the Federal Register only provided a state total of prevalence data.

The WICHE data was computed based on census information from 2000. This data assumes the growth in the number of adults with SPMI is at the same rate as the total population.

Significance: Assuring access to mental health services for individuals suffering from a severe and persistent mental illness is a priority of the Division of Mental Health and the mental health block grant legislation.

Criterion 3: Children's Services

The Division of Mental Health, through the Children's SED Program, promotes the provision of mental health services in a community setting with hospitalization or other out-of-home placement being the choice of last resort. SED services include case management services to assist the child and family with the identification of strengths and needs to create a strength-based, outcome-focused case service plan. Services are provided using a team approach involving the child; family; other service providers such as social services, education, corrections; and any other parties that may be involved with the family including persons chosen by the family such as friends, family members, advocates, etc. Assistance with accessing other community resources or other resources within the community mental health center, such as substance abuse counseling, is also accomplished under the broad spectrum of children's service provision. See Criterion 1 for further information on children's services.

The State of South Dakota has eleven community mental health centers that the Division of Mental Health contracts with to provide mental health services in our communities. Each mental health center has an assigned catchment area, broken out by county, for which they are responsible. (See Attachment 2)

Name of Performance Indicator
Number of youth referred for mental health services through the Intensive Family Services Program (IFS)

Population
Children with serious emotional disturbance.

Criterion 3
Children's Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	78	80	81	82	83

Goal
Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target
Increase in number of children referred through IFS by 1% above current level.

Brief Name
Number referred through IFS.

Indicator
Number of youth referred for mental health services through the Intensive Family Services Program

Source(s) of Information
DMH information system.

Significance
Providing a continuum of services and linkages that allow for strength-based, outcome-focused mental health services for SED youth and their families is a priority of the Division of Mental Health and the mental health block grant legislation.

Criterion 4: Targeted Services to Rural and Homeless Populations

South Dakota is predominantly a frontier State with 66 counties and 76,536 square miles. Nine Indian Nations are spread throughout the state and encompass 15,000 square miles. 754,844 people make up the total population of South Dakota. 8.3% of the total population is Native American and 88.7% is white. Thirty-four of the state's counties are classified as frontier (less than 6 persons per square mile) and 31 are classified as rural (6 to 99 persons per square mile). Minnehaha county in the southeastern part of the state is considered the only urban (100 or more persons per square mile) county.

The barriers faced in mental health service provision in the rural areas of the state are numerous and difficult to overcome. Three Rivers Mental Health and Chemical Dependency Center, in the northwest portion of the state covers the counties of Corson, Dewey, Harding, Mead, Perkins and Ziebach. This also includes areas of the Standing Rock and Cheyenne River Sioux Nations. Southern Plains Behavioral Health Services in the south central region of South Dakota covers the counties of Gregory, Mellette, Todd and Tripp. The Rosebud Sioux Nation is also included in this area. The rural nature of each of these service areas poses some unique challenges in delivery of mental health services. Lack of transportation, high travel time for service providers, lack of appropriate housing and employment opportunities, lack of financial resources to afford medications and basic necessities of daily life, and resistance to traditional mental health services are major issues that will need to be addressed. Psychiatry services in the rural and frontier areas of the state pos a significant challenge to providing a broad continuum of care. Often times psychiatrists are not willing to live and work in these rural and frontier areas, and contracting with those who are willing is not cost effective for the mental health service providers.

According to Section 340® of the Public Health Service Act, a "homeless" individual is defined as an individual with SPMI or SED who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

PATH funds are allocated to all community mental health centers throughout South Dakota. The allocation amounts are based on the need for services. The more urban areas of Sioux Falls and Rapid City have the largest homeless populations; therefore, the need for funding to address the issue of homeless is greatest in these locations. Although smaller numbers are seen in other areas of the state, homelessness remains an issue statewide. Due to this, a smaller amount of funding has been allocated to each of the remaining community mental health centers.

South Dakota's community mental health centers provide services through the CARE program to individuals with severe and persistent mental illness. The children's SED program provides services to children with serious emotional disturbance. The primary goal of PATH is the identification and provision of services to individuals with a severe mental illness and/or dually-diagnosed and children with serious emotional disturbance

and their families, who are homeless, and who have not previously been served or served successfully by community mental health centers.

Additionally, consumers who are unable or unwilling to access existing services will be considered eligible for PATH-funded services. This will result in the availability of comprehensive services that are responsive to individual needs and circumstances.

It is assumed that many of the individuals eligible for services under PATH have historically not linked with the community mental health center system or have received limited services due to sporadic utilization. The ability to provide services in a variety of locations and to consumers who are not tied to a specific funding source should assist individuals in accessing the necessary supports in a less intrusive, more comfortable fashion. An additional benefit is the flexibility for staff to monitor consumer status in a non-clinical setting.

Name of Performance Indicator
Number of children who are homeless, or at risk of homelessness, receiving PATH housing funds.

Population
Children with serious emotional disturbance.

Criterion 4
Targeted Services to Rural and Homeless Populations

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	39.5%	39.6%	39.7%	39.8%	39.9%
Numerator	1,027	1,031	1,033	1,036	1,039
Denominator	2,603	2,603	2,603	2,603	2,603

Goal
Provide comprehensive mental health services to homeless and rural populations of children with SED.

Target
Increase number of homeless individuals served through PATH by .1% above current level.

Brief Name
Number receiving PATH.

Indicator
Number of children who are homeless, or at risk of homelessness, receiving PATH housing funds.

Measure
Numerator: Numbers of adults with SPMI and children with SED who are homeless, or at risk of homelessness, and who receive PATH housing funds during the FY.
Denominator: Estimated number of adults and children who are homeless, or at risk of homelessness.

Source(s) of Information
PATH quarterly reports submitted by CMHCs, and the 1999 Quantitative Assessment of Estimated Number of Homeless Adults, Children and Youth in South Dakota.

Significance
Assuring that PATH resources are being provided appropriately and according to the needs of individuals in the target population is a primary goal of the mental health block grant law and a contingency of PATH funding.

Criterion 5: Management Systems

Targeted amounts in the FY05 budget specifically for children with serious emotional disturbances are $6,225,538. Funding includes Medicaid, block grant, and state general funds. Included in this budget are services provided through the SED program as well as the Indigent Medication program. The entire community-based budget is $21,432,326 and includes services to individuals with SPMI, SED, as well as other services such as outpatient, emergency, protection and advocacy, and the indigent medication program. Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council at their quarterly meetings.

Medicaid is a vital funding component of South Dakota's system of mental health care. On July 1, 1995 the Mental Health Rehabilitative Services Option was added to the Medicaid State Plan. Community mental health center services, previously restricted under the Clinic Option, became much more flexible under the Rehabilitation Option. This transition allowed service provision outside the clinic setting and provided a significant enhancement of service capability, especially in rural communities where transportation options are limited or non-existent. The Rehabilitation Option also allowed the implementation of community-based services, which are more accessible and responsive to individual consumers.

The State of South Dakota provides medical and mental health services to a large number of children eligible for Medicaid. The Department of Social Services' (DSS) budget includes a federally mandated State general fund match to federal Medicaid dollars to provide medical services to children that are Medicaid eligible. In an agreement established through a memorandum of understanding with DSS, the DMH budget includes a federally mandated State general fund match to federal Medicaid dollars to provide mental health services to children that are Medicaid eligible. Through funding provided by the recently created State Children's Health Insurance Program (CHIP), South Dakota's Medicaid program has expanded to cover all children under 19 whose families' incomes are at or below 140% of the federal poverty level. This program began July 1, 1998. It was initially targeted to families at or below 133% of federal poverty level. The eligibility cutoff was increased to the current 140% on July 1, 1999 following the 1999 Legislative Session. In addition, CHIP-NM has been created to allow families, who are not eligible for Medicaid or CHIP and whose incomes are at or below 200% of federal poverty level, to qualify. Each CMHC has made it a priority to educate families on the eligibility criteria and application process for CHIP, as well as the overall advantages to being involved in the program. The Division of Mental Health is also participating in the Covering Kids and Families Initiative, a national program of the Robert Wood Johnson Foundation. This coalition is a unique statewide collaborative representing over 30 different agencies working to increase health care access for low income, uninsured children.

Children's SED services are funded through a fee for service paid for billable fifteen minute units of service. For SFY00 a 20% increase was made in the unit rate for services provided 20 miles from a main or itinerant office. Although no additional dollars were allocated for this change, the "rural rate" will enhance access to funding to centers in

rural and frontier areas with higher expenses due to travel time and non-billable staff time. In SFY02, Three Rivers Mental Health Center in Lemmon and Southern Plains Behavioral Health Services in Winner will use the rural rate for all mental health services delivered to adults with SPMI and children with SED, due to their entire catchment areas being in frontier areas of the state.

Emergency services are also provided through purchase of services agreements with the eleven community mental health centers.

Current rates for services will be evaluated as part of an ongoing process over the entire three years of the State Plan. The Division of Mental Health will provide ongoing training addressing rate change issues, changes in CPT codes, and making our systems compliant with HIPAA requirements.

Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council in their quarterly meetings. The Division of Mental Health uses MIS data to monitor contract and Title XIX Expenditures.

Name of Performance Indicator
Average amount of public funds expended on mental health services for children with SED.

Population
Children with serious emotional disturbance.

Criterion 5
Management Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY2006 Target	FY2007 Target
Performance Indicator	1,268	1,294	1,320	1,345	1,372
Numerator	4,631,190	4,770,125	4,913,229	5,060,626	5,212,445
Denominator	3,650	3,686	3,723	3,760	3,798

Goal
Ensure resources for services to children with SED are allocated based on consumer need.

Target
Increase the amount of public funds expended by 3% through inflationary increases.

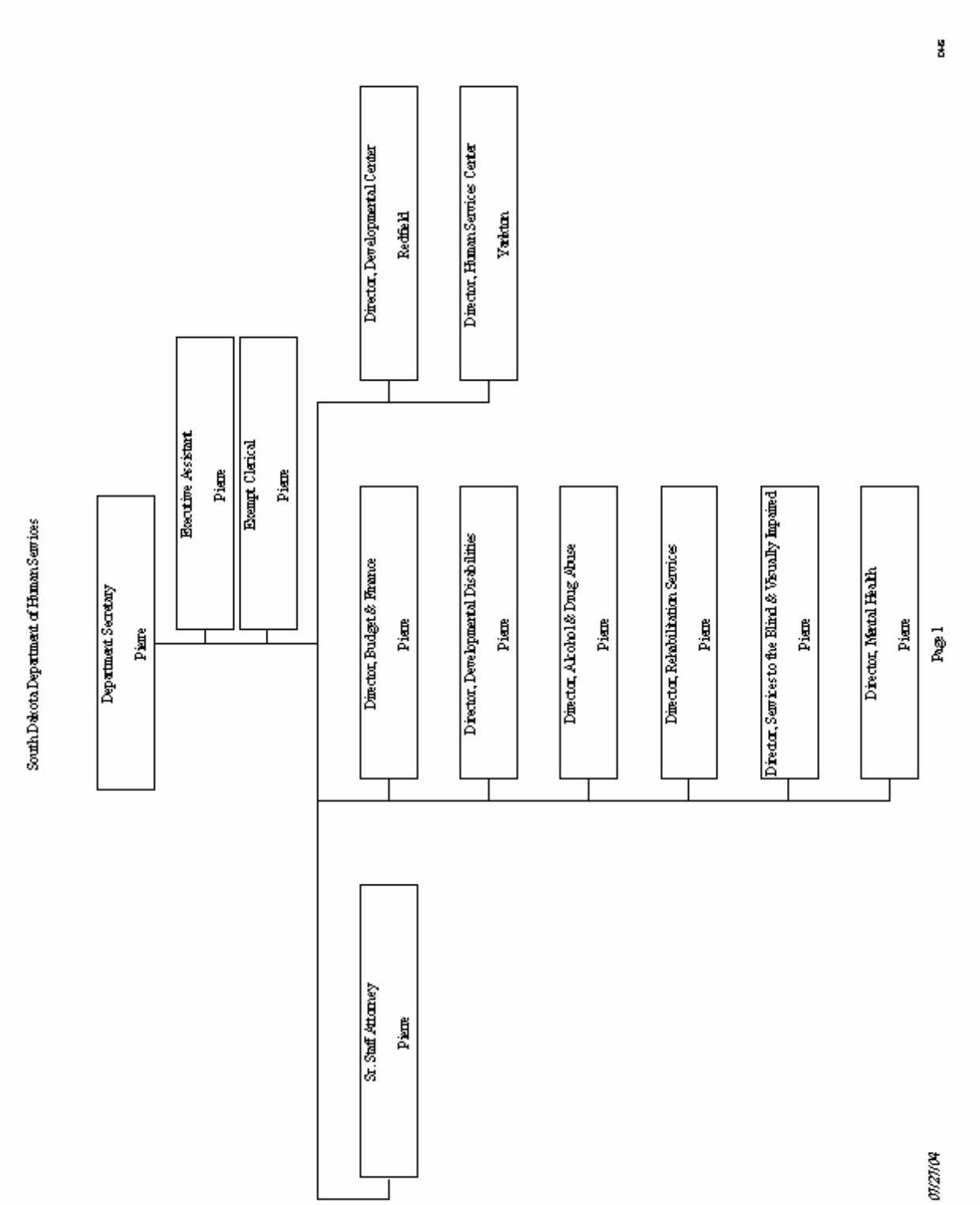
Brief Name
Average resources expended per child with SED.

Indicator
Average amount of public funds expended on mental health services for children with SED.

Measure
Numerator: Total amount of direct service expenditure for children with SED in FY.
Denominator: Total number of children with SED receiving services in FY.

Source(s) of Information
DMH management information system.

Significance
Ensuring resources are allocated appropriately is a priority of the DMH.


South Dakota Department of Human Services
Department Secretary
Pierre
Executive Assistant
Pierre
Exempt Clerical
Pierre
Director, Developmental Center
Redfield
Director, Human Services Center
Yankton
Director, Budget & Finance
Pierre
Director, Developmental Disabilities
Pierre
Director, Alcohol & Drug Abuse
Pierre
Director, Rehabilitation Services
Pierre
Director, Services to the Blind & Visually Impaired
Pierre
Director, Mental Health
Pierre
Sr. Staff Attorney
Pierre
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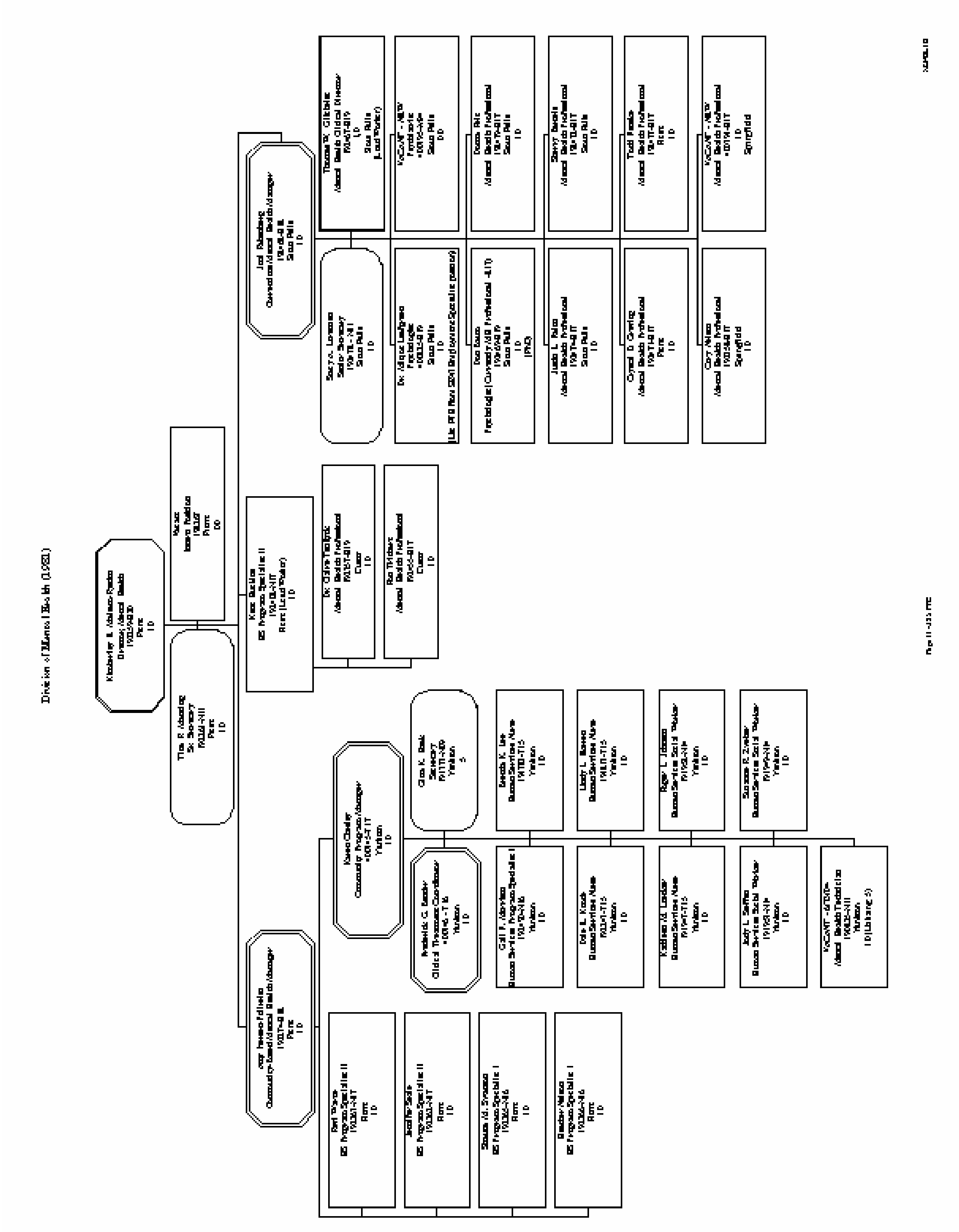
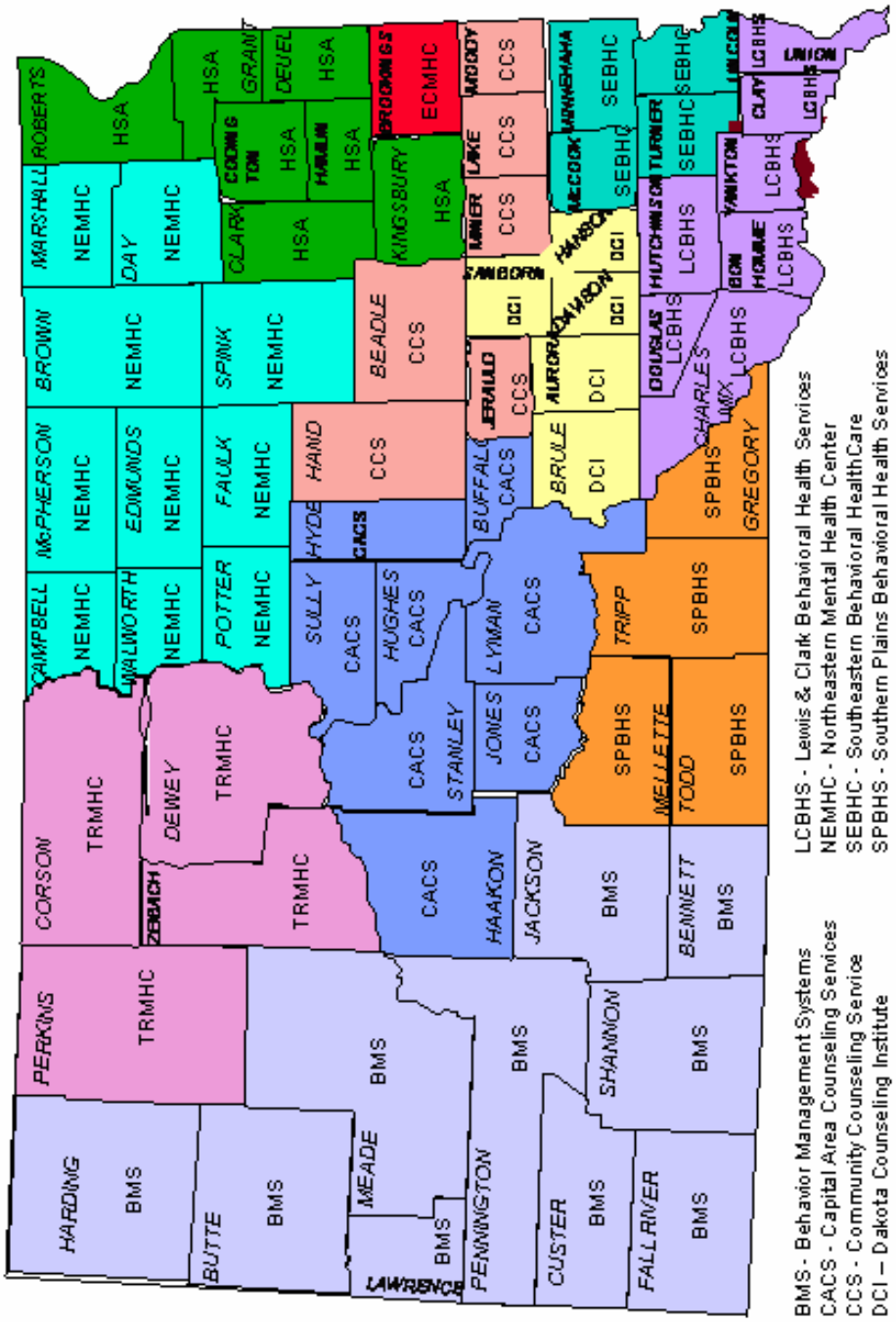


South Dakota Mental Health Center Service Areas



BMS - Behavior Management Systems
CACS - Capital Area Counseling Services
CCS - Community Counseling Service
DCI – Dakota Counseling Institute
ECMHC - East Central Mental Health Center
HSA - Human Service Agency
LCBHS - Lewis & Clark Behavioral Health Services
NEMHC - Northeastern Mental Health Center
SEBHC - Southeastern Behavioral HealthCare
SPBHS - Southern Plains Behavioral Health Services
TRMHC- Three Rivers Mental Health Center

Children's SED Program

Mental Health Services for Children with Severe Emotional Disturbances

The Children's Serious Emotional Disturbance (SED) Program shall be an intensive and comprehensive, child-centered, family-focused, community-based, individualized system of care which delivers mental health services to children with a serious emotional disturbance. The SED program shall provide access to a comprehensive array of services that address a child's physical, psychological, emotional, social and educational needs. The SED program shall provide children with individualized services in accordance with the unique needs and potentials of each child. These services shall be provided to children within the least restrictive, most normative environment that is clinically appropriate, and in a manner that is sensitive and responsive to children's cultural differences and special needs. The parents, families and surrogate families of children with SED will be full participants in all aspects of the evaluation, planning, and delivery of SED services, which shall be integrated with all involved child-serving agencies and programs. The goal of these services is to ensure that children with SED are able to live with their families and in their home community, whenever possible. Community Mental Health Centers shall maintain written policies and procedures for the delivery of services per the requirements outlined in 46:20:13 and this attachment.

PRINCIPLES AND METHODS

A. Case Management

Case management services may be delivered either face-to-face or by telephone with the child, the child's family, significant others, or other involved service providers.

B. Individual Therapy

Face-to-face contact between an identified child and therapist, in which the therapist delivers direct therapy to assist the child in progress toward case service plan goals. If this service is not delivered in the child's home, the more appropriate setting used should be justified and documented in the clinical record.

C. Family Education/Support/Therapy

Face-to-face contact between two or more family members and therapist in which the therapist delivers direct therapy, education relating to the identified child's condition, or support services to develop coping skills for the parents and family members, in regards to the identified child.

D. Crisis Intervention

An immediate therapeutic response available 24 hours a day 7 days a week that involves direct telephone or face-to-face contact with the child exhibiting acute psychiatric symptoms and/or inappropriate behavior, that left untreated, presents an immediate threat to the child or others. Crisis intervention also includes direct telephone or face-to-face contacts with family members or other service providers in an attempt to effectively manage the child's crisis.

E. Collateral Contacts

Treatment of an individual through necessary telephone or face-to-face contact with persons other than the identified child. The information is necessary to plan appropriate treatment, to assist others so they can respond therapeutically regarding the child's difficulty/illness, or to link the child/family to other necessary and therapeutic community supports.

F. Assessment and Evaluation

A face-to-face meeting between or under the supervision of a qualified mental health professional or a clinical supervisor and the child, resulting in a written evaluation of a set of symptoms. The process may result in the indication of a mental disorder or a condition requiring treatment, as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).

G. Psychological Evaluation

Such services must be provided by or under the supervision of a licensed psychologist.

H. Group Therapy for Children with SED

Goal directed, face-to-face therapeutic intervention with the eligible child and one or more children with SED who are treated at the same time. The group focuses on the mental health needs of the children in the group.

I. Parent/Guardian Group Therapy

Goal directed face-to-face therapeutic intervention with the parents/guardians of an eligible child and one or more parents/guardians of children with SED, who are treated at the same time. The group focuses on the mental health needs of the children with SED.

J. Liaison Services

Liaison services must be consistent with treatment goals and intended to minimize the length of hospitalization. Services in the community include the development of community resources, coordination with other support networks and contacts with the individual's family, to assure that changing needs are recognized and appropriately met. Liaison services must be provided to facilitate treatment planning and coordination of services between mental health centers and the following entities:

1. In-patient Psychiatric Hospitalization;
2. Residential Programs;
3. Local Hospitals;
4. Correctional Facilities; and
5. In-patient Drug/Alcohol Treatment Programs.

CLINICAL RECORD

A. Diagnostic/Needs Assessment

The therapist obtains permission from the parent/legal guardian of the child to meet with the referred child and at least one parent/guardian to complete a diagnostic/needs assessment. The meeting can take place in the setting most clinically appropriate, as agreed upon by the family. The diagnostic/needs

assessment must be completed within thirty (30) days of intake, or by the 4th visit, whichever is sooner.

1. Discussion. During the diagnostic/needs assessment phase, the therapist will discuss the following with the child/family:
   a. Describe eligibility criteria;
   b. Describe services available to the child and family under Children's SED services;
   c. Answer any questions regarding the processes and benefits of mental health services provided to child with SED and family members;
   d. Describe the roles of the case manager and therapist; and
   e. Describe the agencies procedure for accessing crisis intervention services.

B. Case Service Plan

A strength based, comprehensive, and individualized case service plan must be developed which includes a clear statement of the problem(s) and goals. The goals, which are clear, specific, and measurable, will correspond to each problem in the case service plan. The case service plan will reflect the needs and strengths of the family as identified in the diagnostic/needs assessment.

1. Requirements. The case service plan shall reflect crisis interventions for those youth at risk of quick decompensation that may result in out of home placement, poses a danger to self or others, or significantly disrupts the home/school environment. The crisis intervention plan shall be specific to the child and his/her situation.

2 Review. The frequency of the review of the case service plan will be largely driven by the needs and requests of the family, suggestions by the other team members, and changes in the child or family situation. The case service plan must be reviewed, at a minimum of once every six months, and in cadence with the minimum requirements set forth for child/family team meetings. Written documentation of the outcome of that review must be dated and signed by those in attendance, including the therapist, child, if appropriate, and family. A copy shall be given to the family after it is signed and also placed in the case file.

3. Revision. If there are requests to revise the case service plan, a child/family team meeting will be held to discuss the recommended changes. Any revisions of the case service plan or specific goals achieved will be documented in the case service plan and will be signed and dated by the therapist, child, if appropriate, and family. There will not be a delay in initiating revisions due to the team's inability to contact a member that was unable to attend the meeting. A copy of the revised case service plan shall be given to the family after it is signed.

C. Progress Notes

1. Individual therapy notes. At a minimum, progress notes must correlate with the goals specified on the case service plan, substantiate all services provided, and include:
   a. Information identifying the child with SED, including the child's name and CID number;

b. The date and location of the service provided;
c. The MIS service activity code or title describing service code
d. The units of service;
e. The staff providing service;
f. A brief assessment of the child's functioning;
g. Information relating to the interventions/methods used;
h. The effectiveness of the interventions and the child's progress toward service plan goals; and
i. A description of and rationale for what is to happen next in treatment.

2. Group therapy notes. One progress note can be used per group therapy session if the note includes the necessary information for each child participating. This information includes:

a. Individual child's level of participation; and
b. Progress toward achieving individualized goals noted on the child's individualized case service plan.

D. Supervisory Assessments

1. If a center's internal quality assurance process addresses the points below, those records, which have undergone a QA review, will be considered as meeting the requirement for an annual supervisory assessment. The work of staff who meet the requirements of a clinical supervisor does not need to be reviewed by another clinical supervisor.

a. Review of progress made toward treatment goals over the past 12 months;
b. Justify continued mental health serviced, if warranted; and
c. Assess the need for additional services.

ADMISSION AND DISCHARGE INFORMATION

A. Eligibility Criteria

1. If the child is below age four (4), prior approval and authorization from the Division of Mental Health is required. Claims will automatically be denied for children under the age of four (4) unless the Division has granted a waiver. Approval is needed for Title XIX and state contract funded services. Only claims for assessments/evaluations will be paid without prior approval.
2. If services cannot be provided immediately to individuals identified as having a serious emotional disturbance, a waiting list shall be developed. In addition to placement on a waiting list, the individual must be provided with the following services:
   a. The provider must follow the expectations outlined on SED Eligibility Form SED-300;
   b. The provider must offer emergency services to the child/family while on the waiting list; and
   c. If a provider refuses to serve an individual, please refer to the expectations in ARSD 46:20:13:12.

REFUSAL TO SERVE A CHILD WITH SED

A. Refusal Process

Providers shall follow the expectations regarding refusal to serve children with SED and their families that are outlined in POLICY MEMORANDUM 01-00 and SED Eligibility Form SED-300. Providers are expected to serve all individuals who meet the South Dakota Division of Mental Health definition of SED. Should a provider refuse services to any consumer the criteria outlined in ARSD 46:20:13:12 must be adhered to.

B. Agency's Right to Appeal

1. Within thirty (30) days of the refusal the Executive Director of the refusing agency may submit a letter to the Director of the Division of Mental Health stating the provider's case for maintaining their contract funds. The Division Director will review the facts, make a determination and respond to the provider within two working weeks of receiving the letter of appeal.
2. Should the Division Director's decision go against the refusing agency, the agency may further appeal the Division's decision by forwarding the information of their justification for refusing to serve the consumer and any additional supporting information to the Division. This information will then be forwarded to four community mental health provider agencies for peer review.
3. Peer reviewers are to make a determination based on the information submitted as to whether the provider agency is justified in the refusal to serve the consumer. The peer reviewer's determination is to be placed in writing and forwarded to the Director of the Division of Mental Health.
4. If the Division Director is in disagreement with the findings of the peer review the Division Director will forward the findings of the peer review, along with the Division Director's recommendation, to the Secretary of the Department of Human Services who will render a decision regarding the position of the Department.

BILLING INFORMATION

A. Cost Centers

Examples of allowable costs are staff salaries and benefits, rent, utilities, building depreciation, maintenance, insurance, capital assets depreciation, supplies and travel. Providers shall participate in the planning, development, and implementation of coordinated transportation efforts. Failure to participate may result in dis-allowance of travel costs.

CHAPTER 46:20:13
CHILDREN'S SERIOUS EMOTIONAL DISTURBANCE PROGRAM

Section

46:20:13:01. Definitions. Terms used in this chapter mean:

(1) "Case manager," a designated staff of a center who identifies needs and strengths, creates a strength-based, outcome-focused case service plan, assists the family in accessing other resources in the community, advocates on behalf of the family, and coordinates services on behalf of the family within the center and with other child-serving agencies in the community and surrounding areas;

(2) "Child and family team," a team identified by the case manager and family who develops the written case service plan, monitors treatment progress, and provides assurance that the services are coordinated and the family's needs are being met;

(3) "Intensive family services," services provided jointly by the department, the Department of Corrections, the Department of Labor, and the Department of Social Services. A pre-aftercare program which is a multi-departmental effort of various state agencies to provide an opportunity to families of children who are placed under the jurisdiction of the Department of Corrections to address issues and access needed services to allow the children to return to their home with the greatest opportunity for success;

(4) "Serious emotional disturbance program" or "SED program," an intensive and comprehensive child-centered, family-focused, community-based, individualized system of care which delivers mental health services to children with serious emotional disturbance; and

(5) "Transition plan," a plan designed to assist a consumer who is receiving SED services at the age of 17 to transition into appropriate adult services, if indicated.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:13:02. SED services -- Case manager responsibilities. The case manager, or therapist, if different than the case manager, shall provide the following services:

(1) Assist in identifying child and family needs and strengths;

(2) Involve the child, family, and any service provider in creating a strength-based, outcome-focused case service plan;

(3) Assist the family in accessing other resources in the community;

(4) Advocate on behalf of the family; and

(5) Coordinate services within the center and with other child-serving agencies and the community and surrounding areas.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:13:03. SED services -- Staff responsibilities. In addition, SED program staff shall provide the following services to the services provided pursuant to § 46:20:12:02:

(1) Identification of a child and family team, which shall include the parents, legal guardian, or individuals with the principal child care responsibility; the child, unless determined clinically inappropriate by the team; the case manager; the therapist, if different from the case manager. The team may also include professionals from other child-serving agencies directly involved in the delivery of services to the child or family, or both; and individuals chosen by the family;

(2) Individual therapy;

(3) Family education, support, and therapy;

(4) Crisis intervention;

(5) Collateral contacts;

(6) Assessment and evaluation;

(7) Psychological evaluation;

(8) Group therapy for children with serious emotional disturbance;

(9) Parent or guardian group therapy; and

(10) Liaison services.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:13:04. Admission information -- Eligibility criteria. The clinical record must contain documentation indicating that at least one child in the family meets the criteria of serious emotional disturbance as defined in SDCL 27A-15-1.1. However, for

purposes of this chapter, the criteria for serious emotional disturbance also includes a child 18 through 21 years of age who needs a continuation of services that were started before the age of 18, in order to realize specific goals or during the transition to adult services and has a mental disorder diagnosed under the DSM-IV-TR as defined in § 46:20:01:01, as long as all the criteria of SDCL 27A-15-1.1 are met with the exception of subdivisions (1) and (3).

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:13:05. Staff qualifications. Center staff providing mental health services to children with serious emotional disturbance shall possess a master's degree in a human services field or a bachelor's degree in a human services field and at least two years experience in family and children's services.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(1).
Law Implemented: SDCL 27A-5-1.

46:20:13:06. Supervision. A clinical supervisor or qualified mental health professional shall provide supervision of staff providing mental health services to children with serious emotional disturbance for a minimum of one hour per week on an individual or group basis.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:13:07. Development and training. A center shall provide for ongoing training and consultation to enable staff and supervisors to carry out their responsibilities effectively within the framework of the SED program model.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:13:08. Clinical record. A center must maintain a clinical record which shall contain the following information:

(1) Identification data which includes:

(a) The child's identification number;
(b) The child's birth date;
(c) The child's living arrangements;
(d) The child's race;
(e) The child's sex; and
(f) The child's service start date;

(2) Concise data on diagnostic and needs assessment to be completed within 30 days of the initial intake which includes:

(a) Identifying information;
(b) Strengths of the child and family;
(c) Presenting problems or chief complaint, or both;
(d) Treatment history including previous treatment, psychiatric hospital admissions, psychotropic and other medications, physical illness, and hospitalizations;
(e) Family history including family relationships and dynamics, and family psychiatric history;
(f) Educational history and needs;
(g) Alcohol and drug abuse;
(h) Legal issues;
(i) Social needs;
(j) Safety needs, with regard to physical acting out or health conditions;
(k) Vocational and financial history and needs;
(l) Behavioral observations or mental status;
(m) Initial formulation and diagnostic impression per DSM-IV-TR;
(n) Serious emotional disturbance determination;
(o) Date, staff signature, and title; and
(p) Clinical supervisor's signature and title, and the date, verifying review of the history information and agreement with the initial diagnosis;

(3) A case service plan with treatment goals that indicate a need for service and specify all services that are being provided by a center and outside entities, to be completed within 30 days of intake and reviewed at least every six months thereafter. The case service plan must be signed by the parent, or guardian, and the child if the child is able, and a copy shall be provided to the child and parent, or guardian. The child and parent, or guardian, may at any time seek a revision to the plan. Transition plans must be implemented by the child's treatment team when a child is receiving serious emotional disturbance program services at the age of 17. A written transition plan must be completed six months prior to the child's eighteenth birthday. The plan must be incorporated into the child's case service plan;

(4) Progress notes that describe the child's goals and document the child's progress in achieving those goals shall be included in the child's record for each billable service provided;

(5) A supervisory assessment completed for any staff who does not meet the requirements of a clinical supervisor. The first supervisory assessment shall be completed within 30 days of the anniversary date of intake and annually thereafter. The clinical supervisor, as part of the supervisory assessments, shall:

(a) Review and sign each child's history to verify diagnosis;
(b) Review progress made toward treatment goals over the past 12 months;
(c) Justify continued mental health services, if warranted;
(d) Assess the need for additional services; and
(e) Approve case service plan reviews; and

(6) If appropriate, signed forms consenting to the release of information, which shall be updated annually.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(2).
Law Implemented: SDCL 27A-5-1.

46:20:13:09. Reimbursable services. Reimbursable services are those services which are limited to face-to-face and collateral contacts, at a minimum of 15 minutes in length, for the purpose of providing comprehensive mental health treatment for children with serious emotional disturbance. Full mental health services contracted through the department shall be provided throughout the contracted period. Any information submitted shall contain the child's name, consumer identification (CID) number, and social security number. Reimbursable services are limited to:

(1) Individual and group therapy;
(2) Family education, support, or therapy specifically relating to the child's serious emotional disturbance;
(3) Crisis intervention;
(4) Evaluations;
(5) Case management services;
(6) Collateral contacts; and
(7) Intensive family services.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:13:10. **Nonreimbursable services.** Nonreimbursable services include:
(1) Vocational services;
(2) Academic educational services;
(3) Services that are solely recreational in nature; and
(4) Services for an individual other then an eligible child with serious emotional disturbance and the child's family.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:13:11. **Co-payments**. Co-payments may not be charged for any SED program services.
Source: 29 SDR 80. effective December 10, 2002.
General Authority: SDCL 27A-5-1(2).
Law Implemented: SDCL 27A-5-1.

46:20:13:12. **Refusal to serve a child with a serious emotional disturbance -- Alternate provider.** The division has the authority to reduce the contract of the refusing provider in order to purchase necessary services from an alternative provider. A center may not refuse services to any child with a serious emotional disturbance unless:

(1) The center provides written notice of the refusal to the division within 72 hours of this action;

(2) The center offers emergency services to the consumer until the consumer can be relocated to another service area or alternative services are arranged; and

(3) The center arranges for appropriate mental health services for the consumer with another provider.

Source: 29 SDR 80, effective December 10, 2002**.**

General Authority: SDCL 27A-5-1(5).

Law Implemented: SDCL 27A-5-1.

46:20:13:13. Discharge information. When discharging a child from the SED program, the center must complete the following:

(1) An outcome determination form that contains the child's name, social security number, and consumer identification (CID) number. This form must be completed and sent to the division within ten working days from date of termination; and

(2) A discharge summary including:

(a) Treatments received and progress made in achieving treatment goals;

(b) Reason for discharge; and

(c) Disposition of referral to other agencies.

Source: 29 SDR 80, effective December 10, 2002.

General Authority: SDCL 27A-5-1(5).

Law Implemented: SDCL 27A-5-1.

CARE Program

Continuous Assistance, Rehabilitation and Education Program

Mental Health Services for Adults with Severe and Persistent Mental Illness

The CARE Program shall be a comprehensive program for providing treatment, rehabilitation, and support services to identified consumers with severe and persistent mental illness. The CARE Program is aimed at helping people with a severe and persistent mental illness live successfully in the community. A CARE Team is organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery team, supervised by a clinical supervisor. Services should stress integration in normal community settings and be responsive to cultural differences and special needs. Outreach to consumers and provision of services according to individual consumer needs shall be the team's highest priority, with the majority of clinical contacts occurring in settings outside of an office setting. Referrals of consumers to other program entities for treatment, rehabilitation and support services may be made as clinically appropriate. Community Mental Health Centers shall maintain written policies and procedures for the delivery of services per the requirements outlined in 46:20:12 and this attachment.

PRINCIPLES AND METHODS

A. Case Management

Case management shall be viewed as a generic service to be provided by a variety of CARE Team staff. Individual professional staff shall be assigned differing case management duties based upon the volume of other specialty duties and abilities as case managers. Effective case management is a result of the CARE Team working to ensure the delivery of a seamless continuum of highly coordinated services to consumers. Each CARE Team is responsible for maintaining an ongoing treatment relationship whether the consumer is in the community, in the hospital, or involved with other agencies (i.e., correctional facility). This treatment relationship shall be maintained even though it may be determined that a given service (i.e., face-to-face contact with a consumer who has been admitted to a hospital) is not billable.

B. Crisis Assessment and Intervention

Crisis assessment and intervention, including telephone and face-to-face contact, will be available to consumers 24 hours per day, seven days per week. This service is to be offered directly by the providing agency, not through an outside emergency service agency.

C. Liaison Services

Liaison services must be consistent with treatment goals and intended to minimize the length of hospitalization. Services in the community include the development of community resources, coordination with other support networks and contacts with the individual's family, to assure that changing needs are recognized and appropriately met. Liaison services must be provided to facilitate treatment

planning and coordination of services between mental health centers and the following entities:

1. In-patient Psychiatric Hospitalization;
2. Residential Programs;
3. Local Hospitals;
4. Correctional Facilities; and
5. In-patient Drug/Alcohol Treatment Programs.

D. Symptom Assessment and Management

Symptom assessment and management, supportive counseling and psychotherapy, when diagnostically indicated, will be provided to help the consumer cope with and gain mastery over symptoms and disabilities in the context of daily living. This shall include, but not necessarily be limited to:

1. Ongoing assessment of the consumer's mental illness symptoms and the consumer's response to treatment;
2. Education, when appropriate, of the consumer regarding his/her illness and the effects and side effects of medications prescribed to regulate it;
3. Symptom management efforts directed to helping each consumer identify the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects; and
4. All staff providing both on a planned and "as needed" basis, psychological support to consumers to help them accomplish their independent living goals and to cope with the stresses of day-to-day living.

E. Medication Prescription, Administration, Monitoring and Documentation

1. The psychiatrist, physician, physician assistant, or certified nurse practitioner shall:
   a. Assess each consumer's mental illness symptoms and behavior and prescribe appropriate medication;
   b. Regularly review and document the consumer's mental illness symptoms as well as his/her response to prescribed medication treatment; and
   c. Monitor, treat and document any medication side effects.
   d. The services provided by a psychiatrist, physician, physician assistant, or certified nurse practitioner shall be billed at a rate separate from other CARE Team services.
2. Only staff trained in the administration of medications, as indicated in ARSD 46:20:12:04 (4), may provide the following:
   a. Assistance with administration of prescription and nonprescription medications prescribed by a psychiatrist, physician, physician's assistant, or certified nurse practitioner for consumers who are incapable of self-administration; and
   b. Instruction in the act of self-administration of prescription and nonprescription medications prescribed for self-administration by a psychiatrist, physician, physician's assistant, or certified nurse practitioner.

3. All CARE Team staff shall assess and document the consumer's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.
4. CARE Programs shall establish medication policies and procedures which shall be in compliance with SD Board of Nursing Standards for handling on-site medications (i.e., administrative office, CARE team meeting place). These procedures must identify processes to:
   a. Record physician's orders;
   b. Order medications;
   c. Arrange for all consumer medications to be organized through the team and integrated into daily and weekly schedules;
   d. Provide security for medications (i.e., daily supplies, long-term injectable, and longer-term supplies) and set aside a private designated area for set up of medications by the team's nursing staff; and
   e. Administer medications to consumers.

F. Direct Assistance

The CARE Team shall provide direct assistance to ensure that the consumer obtains the basic necessities of daily life, and performs basic daily living activities. If a need for assistance in an area is due to something other than the psychiatric disability, referral to other services may be appropriate. For example, if a consumer also has a physical disability, Adult Services and Aging may be contacted for assistance with household chores. The CARE Team shall assist consumers as needed. This assistance includes but is not necessarily limited to:

1. Medical, dental and vision services;
2. Support in helping consumers find and maintain employment in community-based job sites;
3. Budgeting and financial support, including payee services through the provider agency;
4. Linking to social service agencies;
5. Legal advocacy and representation;
6. Performing personal hygiene tasks;
7. Performing household chores, including housecleaning, cooking, laundry, and shopping;
8. Using community transportation;
9. Locating, financing and maintaining safe, clean, affordable housing; and
10. Collaboration with substance abuse services, as needed, shall include but not be limited to individual and group interventions to assist consumers to:
    a. If substance abuse is suspected or known, referrals to an appropriate substance abuse provider and collaboration with the substance abuse provider and treatment plan shall be completed;
    b. Recognize the relationship between substance abuse and mental illness and psychotropic medications;
    c. Develop motivation for decreasing substance use; and
    d. Develop coping skills and alternatives to minimize use.

Direct assistance activities may be performed by a community supportive care worker under the supervision of professional staff from the CMHC. Supervision shall be provided to each community supportive care worker at least monthly. Activities performed by community supportive care workers must not duplicate professional mental health services. Community supportive care workers provide opportunities to practice social skills and broaden the natural support system of adults with severe and persistent mental illness. The documentation of services will be retained in the clinical record.

G. Development of Psychosocial Skills

The CARE Team shall assist in the development of psychosocial skills which include, but are not necessarily limited to:

1. Helping individual consumers develop social skills;
2. Building relationships with landlords, neighbors and others effectively; and
3. Develop assertiveness and self-esteem, as necessary.

H. Family Participation

As clinically appropriate, the CARE Team shall encourage the active participation of the family and/or supportive social network, by providing the following:

1. Education about the consumer's illness and their role in the therapeutic process;
2. Supportive counseling related to the consumer and issues surrounding his/her illness; and
3. Intervention to resolve conflict.

I. Staff

Communication and Planning. The CARE Team shall establish a system for communication and planning that provides a means for the Team to assess the day-to-day progress and status of all consumers. The CARE Team shall identify all treatment and service contacts which staff must carry out to fulfill the goals and objectives in each treatment plan. Daily staff coordination meetings, daily logs, weekly consumer contact schedules, and daily team assignment schedules are suggested methods for effective communication and planning.

J. Hours of Operation and Coverage

The CARE Team shall be available to provide treatment, rehabilitation and support activities seven days per week, 24 hours per day as clinically necessary. The CARE Team shall have the capacity to provide multiple contacts per week to consumers experiencing severe symptoms and/or significant problems in daily living. The CARE Team shall have the capacity to increase the service intensity to a consumer within one to two hours of his/her status requiring it.

CLINICAL RECORD

A. Consumer History/Record

For consumers receiving only medication evaluation and management services, the consumer history must be completed within 30 days, and contain the following:

a. Identifying information;
b. Presenting problems/chief complaint;
c. Treatment history containing sufficient information to define consumer needs, support the diagnosis, determine SPMI eligibility, and guide treatment;
d. Initial formulation and diagnostic impression per DSM-IV;
e. Initial plan recommendation; and
f. Date, clinician's signature, and title.

B. Case Service Plan

The CARE Team shall develop and update a written case service plan for each person receiving services. Case service plans must be current and must obtain specific goals according to consumer need. If applicable, these goals must reflect special treatment interventions being taken to avoid discontinuation of medications and involvement with the criminal justice system. Case service plans shall reflect relapse interventions for those consumers who are most likely to quickly decompensate and need hospitalization. The case service plan shall be developed collaboratively with the consumer present. Goals and objectives must be specific measurable and written in a way that is easily understood by the consumer. Whenever possible, the case service plan should be signed by the person receiving services or a written notation should be made stating the reason the signature is not present. Supervisory approval will be indicated by the supervisor's signature on the case service plan. To develop a written individual case service plan as required by ARSD 46:20:12:05, the CARE Team must:

1. Access provider records of all known physical and mental health providers involved in the consumer's care;
2. Assess consumer's needs based on documentation relating to medical, social, educational and vocational services; and
3. Document consumer's input pertaining to the formulation of the individual case service plan.

C. Progress Notes

Progress notes must correlate with the observable and measurable goals specified on the case service plan. Group therapy progress notes must include each member's level of participation and progress toward achieving individualized goals. One progress note can be used per group therapy session if the note includes each person's level of participation and progress toward achieving specified goals. If multiple contacts occur within the same day, one progress note can summarize all contacts. At a minimum, progress notes must substantiate all services provided and include:

1. Information identifying the person receiving services, including the name and CID number;

2. The date and location of the service provided;
3. The MIS service activity code or title describing service code;
4. Units of service;
5. The staff providing the service;
6. A brief assessment of person's functioning;
7. Information relating to the interventions/methods used;
8. The effectiveness of the intervention and the consumer's progress toward case service plan goals; and
9. Description of and rationale for what is to happen next in treatment.

D. Supervisory Assessments

1. If a center's internal quality assurance process addresses the points below, those records which have undergone a QA review will be considered as meeting the requirement for an annual supervisory assessment. The work of staff who meet the requirements of a clinical supervisor does not need to be reviewed by another clinical supervisor.
   a. Review of progress made toward treatment goals over the past 12 months;
   b. Justify continued mental health serviced, if warranted; and
   c. Assess the need for additional services.
2. In addition, under the supervision of the program director or his/her designee, treatment planning meetings shall:
   a. Convene at regularly scheduled times, per a written schedule maintained by the program director; and
   b. Occur with sufficient frequency and duration to develop a written individual case service plan that is reviewed every six months, and revised when necessary

ADMISSION

A. Admission Information

If services cannot be provided immediately to individuals identified as having a severe and persistent mental illness, a waiting list shall be developed. In addition to placement on a waiting list, the individual must be provided with the following services:

1) The provider must follow the expectations outlined in POLICY MEMORANDUM 99-01 and SPMI Eligibility Form CARE-200;
2) The provider must offer emergency services to the consumer while on the waiting list; and
3) If a provider refuses to serve an individual, please refer to the expectations in ARSD 46:20:12:09.

REFUSAL TO SERVE AN SPMI CONSUMER

A. Refusal Process

Providers shall follow the expectations regarding refusal to serve SPMI consumers that are outlined in POLICY MEMORANDUM 99-01 and SPMI Eligibility Form CARE-200. Providers are expected to serve all individuals who meet the South Dakota Division of Mental Health definition of SPMI. Should a

provider refuse services to any consumer the criteria outlined in 46:20:12:09 must be adhered to.

B. Agency's Right to Appeal

5. Within thirty (30) days of the refusal the Executive Director of the refusing agency may submit a letter to the Director of the Division of Mental Health stating the provider's case for maintaining their contract funds. The Division Director will review the facts, make a determination and respond to the provider within two working weeks of receiving the letter of appeal.
6. Should the Division Director's decision go against the refusing agency, the agency may further appeal the Division's decision by forwarding the information of their justification for refusing to serve the consumer and any additional supporting information to the Division. This information will then be forwarded to four community mental health provider agencies for peer review.
7. Peer reviewers are to make a determination based on the information submitted as to whether the provider agency is justified in the refusal to serve the consumer. The peer reviewer's determination is to be placed in writing and forwarded to the Director of the Division of Mental Health.
8. If the Division Director is in disagreement with the findings of the peer review the Division Director will forward the findings of the peer review, along with the Division Director's recommendation, to the Secretary of the Department of Human Services who will render a decision regarding the position of the Department.

BILLING INFORMATION

A. Cost Centers

Examples of allowable costs are staff salaries and benefits, rent, utilities, building depreciation, maintenance, insurance, capital assets depreciation, supplies and travel. Providers shall participate in the planning, development, and implementation of coordinated transportation efforts. Failure to participate may result in dis-allowance of travel costs.

CHAPTER 46:20:12
CONTINUOUS ASSISTANCE, REHABILITATION, AND EDUCATION PROGRAM

Section

46:20:12:01. Definitions. Terms used in this chapter mean:

(1) "Continuous assistance, rehabilitation, and education program" or "CARE program," a comprehensive program for providing treatment, rehabilitation, and support services to consumers with severe and persistent mental illness;

(2) "Continuous assistance, rehabilitation, and education team" or "CARE team," a team organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery team and supervised by a clinical supervisor.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:12:02. CARE services -- CARE team responsibilities. The CARE team shall assume responsibility for performing case management duties for consumers with severe and persistent mental illness, which include:

(1) Maintaining current assessments and evaluations;

(2) Participating in the treatment planning process;

(3) Monitoring consumer progress;

(4) Assisting in locating, coordinating and monitoring medical, social, vocational, and psychiatric services as needed;

(5) Developing a plan to manage consumer's financial resources, including payee services as needed;

(6) When appropriate, locating and maintaining suitable living environments, emergency services, and other activities necessary to maintain psychiatric stability in a community-based setting; and

(7) Providing the following services:

(a) Crisis assessment and intervention;

(b) Liaison services;
(c) Symptom assessment and management;
(d) Medication prescription administration, monitoring, and documentation;
(e) Direct assistance;
(f) Development of psychosocial skills;
(g) Encouragement for active participation of family and supportive social network; and
(h) A system for communication and planning.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:12:03. Admission information -- Eligibility criteria. Enrollment in the CARE program shall be limited to consumers who meet the following severe and persistent mental illness eligibility criteria:

(1) The consumer's severe and persistent emotional, behavioral, or psychological disorder causes the consumer to meet at least one of the following criteria:

(a) The consumer has undergone psychiatric treatment more intensive than outpatient care and more than once in a lifetime, such as, emergency services, alternative residential living, or inpatient psychiatric hospitalization;

(b) The consumer has experienced a single episode of psychiatric hospitalization with an Axis I or Axis II diagnosis per the DSM-IV-TR as defined in § 46:20:01:01;

(c) The consumer has been treated with psychotropic medication for at least one year; or

(d) The consumer has had frequent crisis contact with a center, or another provider, for more than six months as a result of a severe and persistent mental illness; and

(2) The consumer's severe and persistent emotional, behavioral, or psychological disorder meets at least three of the following criteria:

(a) The consumer is unemployed or has markedly limited job skills or poor work history;

(b) The consumer exhibits inappropriate social behavior which results in concern by the community or requests for mental health or legal intervention;

(c) The consumer is unable to obtain public services without assistance;

(d) The consumer requires public financial assistance for out-of-hospital maintenance;

(e) The consumer lacks social support systems in a natural environment, such as close friends and family, or the consumer lives alone or is isolated; or

(f) The consumer is unable to perform basic daily living skills without assistance.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:12:04. Staff qualifications. A CARE team shall employ a minimum of four full-time equivalent staff and a full or part-time psychiatrist. Minimum qualifications of staff are as follows:

(1) A full-time program director with a master's degree in a mental health or related field, or a registered nurse, and at least two years of supervised clinical experience in a mental health setting;

(2) A full or part-time registered nurse to effectively meet the needs of the number of consumers served. CARE teams may share the services of a registered nurse;

(3) All CARE team staff providing case management services shall have at least an associate degree in the social sciences or have equivalent experience or a combination of both; and

(4) All CARE team staff shall complete a medication administration training course in accordance with the standards of the Board of Nursing as set forth in §§ 20:48:04.01:09 to 20:48:04.01:15, inclusive, and demonstrate the required level of proficiency outlined in those standards.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(1).
Law Implemented: SDCL 27A-5-1.

Cross-Reference: Delegation of Nursing Tasks, ch 20:48:04.01.

46:20:12:05. Clinical record. A clinical record shall contain the following information:

(1) Consumer identification data which includes:
- (a) The consumer's identification number;
- (b) The consumer's birth date;
- (c) The consumer's living arrangements;
- (d) The consumer's race;
- (e) The consumer's sex; and
- (f) The consumer's service start date;

(2) Concise data on the consumer's history to be completed within 30 days of the intake which includes:
- (a) Identifying information;
- (b) Presenting problems or chief complaint, or both;
- (c) Treatment history including previous treatment, psychiatric hospital admissions, psychotropic and other medications, physical illness, and hospitalizations;
- (d) Family history including family relationships and dynamics, and family psychiatric history;
- (e) Alcohol and drug abuse;
- (f) Legal issues;
- (g) Social needs;
- (h) Safety needs, with regards to physical acting out or health conditions;
- (i) Educational, vocational, and financial history;
- (j) Behavioral observations or mental status;

(k) Sufficient information to determine severe and persistent mental illness eligibility;

(l) Initial formulation and diagnostic impression pursuant to the DSM-IV-TR;

(m) Date, staff signature, and title; and

(n) Licensed mental health professional or clinical supervisor's signature and title, and the date, verifying review of the history information and agreement with the initial diagnosis;

(3) A case service plan with treatment goals that indicate a need for service and specify all services that are being provided by the center and other outside entities, to be completed within 30 days of intake, and reviewed at least every six months thereafter;

(4) Progress notes that describe the consumer's goals and the consumer's progress in achieving those goals and documented in the consumer's record for each billable service provided;

(5) A supervisory assessment completed for any staff who does not meet the requirements of a clinical supervisor. The first supervisory assessment shall be completed within 30 days of the anniversary date of intake and annually thereafter. The clinical supervisor, as part of the supervisory assessment, shall:

(a) Review and sign each consumer's history to verify diagnosis;

(b) Review progress made toward treatment goals over the past 12 months;

(c) Justify continued mental health services, if warranted;

(d) Assess the need for additional services; and

(e) Approve case service plan reviews; and

(6) If appropriate, signed forms consenting to the release of information, which shall be updated annually.

Source: 29 SDR 80, effective December 10, 2002.

General Authority: SDCL 27A-5-1(2).

Law Implemented: SDCL 27A-5-1.

46:20:12:06. Reimbursable services. Reimbursable services are those services which are limited to face-to-face contacts, at a minimum of 15 minutes in length, for the purpose of providing comprehensive treatment, rehabilitation, and support services. Billable contacts under the CARE daily rate are limited to one contact per consumer per day even though multiple contacts may take place. All mental health services contracted through the division must be provided throughout the entire contract period. Reimbursable services are limited to:

(1) Comprehensive medical and psychosocial evaluations;

(2) Physician services, except psychiatric services provided by a psychiatrist or physician assistant;

(3) Nursing services, except psychiatric services provided by a certified nurse practitioner;

(4) Medication monitoring and education;

(5) Psychotherapy;

(6) Emergency services;

(7) Psychosocial rehabilitative therapy;

(8) Development of psychosocial skills; and
(9) Ongoing employment support.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:12:07. Nonreimbursable services. Nonreimbursable services include:
(1) Vocational services;
(2) Academic educational services;
(3) Services which are solely recreational in nature;
(4) Services with individuals other than eligible consumers;
(5) Services delivered by telephone; and
(6) Services provided in an institution for mental disease.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:12:08. Co-payments. Co-payments may not be charged for any CARE services.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(2).
Law Implemented: SDCL 27A-5-1.

46:20:12:09. Refusal to serve a consumer with a severe and persistent mental illness -- Alternate provider. The division has the authority to reduce the contract of the refusing provider in order to purchase necessary services from an alternative provider. A center may not refuse services to any consumer with a severe and persistent mental illness unless:

(1) The center provides written notice of the refusal to the division within 72 hours of its refusal;

(2) The center offers emergency services to the consumer until such time as the consumer can be relocated to another service area or alternative services are arranged; and

(3) The center arranges for appropriate mental health services with another provider to serve the consumer.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:12:10. Discharge criteria. Discharge from a CARE program may occur when:

(1) The consumer moves outside of a geographic area of responsibility. In such cases, whenever possible, the CARE team must arrange for transfer of mental health service responsibility to a provider within the catchment area where the consumer is moving;

(2) The consumer demonstrates an ability to function in all major life areas such as work, socialization, and self-care, without requiring assistance from the program; or

(3) The consumer refuses to participate in CARE program services for more than three consecutive months. During the three month period the center shall keep the consumer's case open and make reasonable attempts to contact the consumer. If refusal continues, or contact cannot be made within three months, discharge may be pursued.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:12:11. Discharge documentation. A consumer receiving services may not be discharged from the CARE program without prior notification, documentation, and approval by the division. Documentation to the division must include:

(1) Reason for discharge;

(2) Consumer's status and condition at discharge;

(3) Written evaluation summary of the progress toward the goals set forth in the case service plan;

(4) A plan for care and follow-up developed in conjunction with the consumer, if applicable; and

(5) Signature of the clinical supervisor, qualified mental health professional, or CARE team manager.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

IMPACT Program

Individualized and Mobile Program of Assertive Community Treatment

Mental Health Services for Adults with Severe and Persistent Mental Illness

The IMPACT Program shall be a comprehensive program for providing treatment, rehabilitation, and support services to identified consumers who are the most severely mentally ill and require the most intensive services. The IMPACT Program serves consumers who have historically failed in community settings and who have had frequent hospitalizations. The IMPACT Program is aimed at helping people with severe and persistent mental illness live successfully in the community and reduce the need for repeated or prolonged psychiatric hospitalizations. An IMPACT Team is organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery system, supervised by a clinical supervisor. Services should stress integration in normal community settings and be responsive to cultural differences and special needs. Outreach to consumers and provision of services according to individual consumer needs shall be the team's highest priority, with the majority of clinical contacts occurring in settings outside of an office setting. Referrals of consumers to other program entities for treatment, rehabilitation and support services may be made as clinically appropriate. Community Mental Health Centers shall maintain written policies and procedures for the delivery of services per the requirements outlined in 46:20:15 and this attachment.

PRINCIPLES AND METHODS
See CARE Attachment 4.

CLINICAL RECORD
See CARE Attachment 4.

ADMISSION INFORMATION
All referrals to IMPACT Programs must meet the criteria outlined in ARSD 46:20:15:03 and be submitted to the Division of Mental Health for approval. The following information must be included with referrals: IMPACT referral form signed by the psychiatrist, psychiatric/psychological evaluation, psychiatric progress notes, and intake summary.

REFUSAL TO SERVE AN SPMI CONSUMER
See CARE Attachment 4.

BILLING INFORMATION
IMPACT services are billable at a higher rate than CARE. For other billing information see CARE Attachment 4.

CHAPTER 46:20:15
COMMUNITY SUPPORT SERVICES PROGRAM -- INDIVIDUALIZED AND MOBILE PROGRAM OF ASSERTIVE COMMUNITY TREATMENT

Section

46:20:15:01. Definitions. Terms used in this chapter mean:

(1) "Individualized and mobile program of assertive community treatment" or "IMPACT," a program providing medically related treatment, rehabilitative, and support services to eligible consumers through a self-contained program of clinicians grouped together as a continuous treatment team under the supervision of a clinical supervisor. These services are provided regardless of location or frequency to assist the consumer with severe and persistent mental illness cope with the symptoms of their illness, minimize the effects of their illness, or maximize their capacity for independent living and prevent or minimize periods of psychiatric hospital treatment;

(2) "Associate clinician," an individual with a bachelor's degree in a human services field with at least one year of post-bachelor's degree experience providing services to consumers with mental illness, or an individual with a bachelor's degree in any field with at least two years of post-bachelor's degree experience providing services to consumers with mental illness, or a registered nurse;

(3) "Clinical staff," clinical supervisors, clinicians, associate clinicians, and clinician assistants;

(4) "Clinical supervisor," a mental health professional who has at least a master's degree in psychology, social work, counseling, or nursing, and two years of supervised

postgraduate clinical experience in a mental health setting, or a qualified mental health professional pursuant to SDCL 27A-1-3;

(5) "Clinician," an individual with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation, or a related field, from an accredited college or university, or a bachelor's level registered nurse with a certificate in mental health nursing from the American Nurses Association;

(6) "Clinician assistant," an individual with an associate's degree in a human services field or an individual who has graduated from high school or has obtained a GED and who has at least two years of experience providing services to consumers with mental illness;

(7) "Program director," an individual with at least two years of post-bachelor's degree clinical or administrative experience providing services to consumers with mental illness; and

(8) "Inpatient treatment," mental health diagnosis, observation, evaluation, care, treatment, or rehabilitation rendered inside or on the premises of an inpatient psychiatric facility.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:15:02. IMPACT program -- Services. The program staff shall provide the following services:

(1) Medication prescription, administration, monitoring and documentation, in accordance with chapter 46:20:12;

(2) Maintaining up-to-date assessments and evaluations;
(3) Participation in the treatment planning process;
(4) Monitoring consumer progress;
(5) Assistance in locating, coordinating, and monitoring medical, social, and psychiatric services;
(6) Development of a plan to manage a consumer's financial resources, including payee services;

(7) Locating and maintaining appropriate living environments;
(8) Emergency services; and
(9) Other activities necessary to maintain psychiatric stability in a community-based setting.

IMPACT services may not exceed a ratio of at least one primary therapist for every 12 consumers served. A center must provide consumers with an average of 16 contacts per month with IMPACT staff and more often if clinically appropriate.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:15:03. Admission information. A consumer is eligible to receive IMPACT services when:

(1) The consumer has a medical necessity to receive IMPACT services, as determined by a clinical supervisor;

(2) The consumer is approved by the division to receive IMPACT services;

(3) The consumer voluntarily consents to receive IMPACT services or is under transfer of commitment from the Human Services Center;

(4) The consumer's severe and persistent emotional, behavioral, or psychological disorder causes the consumer to meet at least three of the four following criteria:

(a) The consumer has undergone psychiatric inpatient treatment more than once;

(b) The consumer has experienced a single episode of psychiatric hospitalization of at least six months duration;

(c) The consumer has been treated with psychotropic medication for at least one year; or

(d) The consumer is currently residing on an inpatient psychiatric unit;

(5) The consumer's severe and persistent emotional, behavioral, or psychological disorder causes the consumer to meet at least six of the nine following criteria:

(a) The consumer is unemployed or has markedly limited job skills or a poor work history;

(b) The consumer is employed in a sheltered setting;

(c) The consumer exhibits inappropriate social behavior which results in concern by the community or requests for mental health or legal intervention;

(d) The consumer in unable to obtain public services without assistance;

(e) The consumer requires public financial assistance for out-of-hospital maintenance or has difficulty budgeting public financial assistance or requires ongoing training in budgeting skills, or needs a payee;

(f) The consumer lacks social support systems in a natural environment, such as close friends, or lives alone or is isolated;

(g) The consumer is unable to perform basic daily living skills without at least weekly assistance, intervention, or training;

(h) The consumer is in constant or cyclical turmoil with family or the social system or is unable to integrate into a community support network resulting in social isolation or being ostracized in the community; or

(i) The consumer is a noncompliant recipient of mental health services when clear need is evident or the consumer is noncompliant with taking psychotropic medication without frequent encouragement, support, or reminders;

(6) The consumer has an Axis I or Axis II diagnosis listed in the DSM-IV as defined in § 46:20:01:01;

(7) No other appropriate community-based mental health service is available for the consumer; and

(8) The consumer understands the IMPACT model and is willing to sign releases of information to obtain medical history information and to include other service providers and supports in the consumer's treatment.

Source: 29 SDR 80, effective December 10, 2002.

General Authority: SDCL 27A-5-1(5).

Law Implemented: SDCL 27A-5-1.

46:20:15:04. IMPACT services provided by designated personnel. The following personnel may provide the following services:

(1) A clinician assistant may provide emergency services and psychiatric rehabilitative services under the supervision of a clinician;

(2) An associate clinician may provide emergency services or psychiatric rehabilitative services under the supervision of a clinician, and if a registered nurse, may provide physician services under the supervision of a psychiatrist. An associate clinician may also provide rehabilitative psychotherapy, under the supervision of a clinician;

(3) A clinician may provide emergency services, rehabilitative psychotherapy, psychiatric rehabilitative services, and physician services if the clinician is a registered nurse under the supervision of a physician, and comprehensive medical and psychosocial evaluations under the supervision of a psychiatrist;

(4) A clinical supervisor may provide any of the services provided by a clinician assistant, associate clinician, or clinician without supervision except services which require the supervision of a psychiatrist. A clinical supervisor, if a registered nurse, may provide physician services only under the supervision of a psychiatrist. Each IMPACT agency must employ a clinical supervisor who will design and supervise the provision of services to consumers and monitor the IMPACT agency's quality assurance program. The clinical supervisor shall devote a minimum of five hours per week for direct supervision of IMPACT clinical staff. Supervision of IMPACT clinical staff may be provided individually or in a group and documentation as to the date, duration, and nature of supervision must be maintained. Clinical supervision specific to an individual consumer is to be documented in a progress note describing the supervision given and maintained in the consumer's record;

(5) A psychiatrist may provide any of the services provided by a clinician assistant, associate clinician, or clinician and physician services without supervision. The psychiatrist must meet face to face with consumers being treated with psychotropic medication at least once per month. Evaluations must be documented in the consumer's medical records; and

(6) Clinical staff may provide any service they are qualified to provide as outlined in this chapter.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:15:05. Requirement for designation and duties of primary therapist. The clinical supervisor must designate a clinician or associate clinician as a consumer's primary therapist. The designation shall be in writing and included in each consumer's file. The designation must be updated as consumer or personnel needs require. Each IMPACT agency must have a backup policy to be implemented when a primary therapist is not available to serve a consumer's needs. A clinician or associate clinician acting as primary therapist shall:

(1) Maintain an orderly and complete clinical file for the consumer which includes:

(a) Documentation that written assessments for the consumer are completed;
(b) A current case service plan; and
(c) Documentation of services and consumer responses to treatments;

(2) Conduct and participate in treatment planning and case conferences with other staff of the IMPACT agency and with others authorized by the consumer;

(3) Maintain a therapeutic alliance with the consumer;

(4) Refer and link the consumer to all needed services provided outside of the IMPACT agency;

(5) Follow-up to ensure that all needed services provided outside of the IMPACT agency are received and monitor the benefit of those services to the consumer;

(6) Coordinate face-to-face meetings with the consumer at least one time per week and a minimum of 16 times per month with IMPACT team members;

(7) Coordinate the provision of IMPACT emergency services and hospital liaison services when the consumer is in a crisis;

(8) Coordinate overall independent living assistance services and work with community agencies to develop needed resources including housing, employment options, and income assistance;

(9) Support and consult with the consumer's family or other support network; and

(10) Act as a consumer advocate.

Source: 29 SDR 80, effective December 10, 2002.

General Authority: SDCL 27A-5-1(5).

Law Implemented: SDCL 27A-5-1(5).

46:20:15:06. Clinical record. A clinical record shall contain the following information:

(1) Consumer identification data which includes:

(a) The consumer's identification number;
(b) The consumer's birth date;
(c) The consumer's living arrangements;
(d) The consumer's race;
(e) The consumer's sex; and
(f) The consumer's service start date;

(2) Concise data on the consumer's history to be completed within 30 days of intake which includes:

(a) Identifying information;
(b) Presenting problems or chief complaint, or both;
(c) Treatment history including previous treatment, psychiatric hospital admissions, psychotropic and other medications, physical illness, and hospitalizations;
(d) Family history including family relationships and dynamics, and family psychiatric history;
(e) Alcohol and drug abuse;
(f) Legal issues;
(g) Social needs;
(h) Safety needs, with regard to physical acting out or health conditions;

(i) Educational, vocational, and financial history;
(j) Behavioral observations or mental status;
(k) Sufficient information to determine severe and persistent mental illness eligibility;
(l) Initial formulation and diagnostic impression per DSM-IV-TR;
(m) Date, staff signature, and title; and
(n) Licensed mental health professional or clinical supervisor's signature and title, and the date, verifying review of the history information and agreement with the initial diagnosis;

(3) An initial case service plan to be completed on the first day of contact, followed by a case service plan with treatment goals that indicate a need for service and specify all services that are being provided by the IMPACT program and other outside entities, to be completed within 30 days of intake, and reviewed at least every six months thereafter;
(4) Progress notes that describe the consumer's goals and the consumer's progress in achieving those goals, documented in the consumer's record for each reimbursable service provided;
(5) A supervisory assessment completed for any staff who does not meet the requirements of a clinical supervisor. The first supervisory assessment shall be completed within 30 days of the anniversary date of intake and annually thereafter. The clinical supervisor, as part of the supervisory assessments, shall:
(a) Review and sign each consumer's history to verify diagnosis;
(b) Review progress made toward treatment goals over the past 12 months;
(c) Justify continued mental health services, if warranted;
(d) Assess the need for additional services; and
(e) Approve case service plan reviews; and
(6) If appropriate, signed forms consenting to the release of information which shall be updated annually.
Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(2).
Law Implemented: SDCL 27A-5-1.

46:20:15:07. Daily clinical staff meetings. IMPACT clinical staff must meet daily, excluding weekends and holidays, to review consumer contacts and consumer status, and to plan for additional consumer contacts as needed. The center must have a written policy pertaining to daily meetings. The clinical supervisor, or other staff designated by the clinical supervisor, shall lead the daily meeting and keep a written log of meeting discussions, dates, and participants.
Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:15:08. Weekly treatment planning and review meetings. IMPACT clinical staff shall meet at least weekly to conduct treatment planning and review meetings. The clinical supervisor, or other staff designated by the clinical supervisor,

shall lead the treatment planning and review meetings, keep a written log of meeting dates and participants, and maintain a schedule of upcoming treatment planning and review meetings.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:15:09. Reimbursable services. Reimbursable services are limited to:

(1) Comprehensive medical and psychosocial evaluation. A multi-functional assessment of the consumer conducted by a physician, and clinicians under the supervision of the physician, to establish the medical necessity of providing services to a consumer by the community support services program provider and to formulate an individual case service plan. The comprehensive medical and psychosocial evaluation shall include the following assessments:

(a) Extent and effects of drug abuse or alcohol use, or both;
(b) Medical systems survey and physical examination;
(c) Medication history;
(d) Psychiatric and mental status examinations;
(e) Diagnosis on all axis in accordance with DSM-IV-TR criteria as defined in § 46:20:01:01; and
(f) Clinical risk factors;

(2) Psychiatric services, which include psychiatric assessments, treatment, and prescription of pharmacotherapy. Psychiatric nursing services including components of physical assessment, medication assessment, and medication administration provided by registered nurses and licensed practical nurses shall be provided under the personal supervision of a physician. All psychiatric services must be provided by qualified staff employed by or under contract with the provider;

(3) Emergency services as defined in § 46:20:01:01;

(4) Counseling and psychotherapy services, which are provided when medically necessary during direct and face-to-face contact with the consumer available on a 24-hour basis. Counseling services are provided within the context of the goals of the program's clinical intervention as stated in the consumer's case service plan. Its purpose is to help the consumer achieve psychiatric stability. Psychotherapy includes several highly specific modalities of therapy, each based on an empirically valid body of knowledge about human behavior. The assessments, case service plans, and progress notes in a consumer's records must justify, specify, and document the initiation, frequency, duration, and progress of such specific modalities of psychotherapy; and

(5) Psychiatric rehabilitative services, which is rehabilitative therapy provided on an individual and small group basis to assist the consumer to gain or relearn the self-care, interpersonal, and community living skills needed to live independently and sustain medical and psychiatric stability. Psychiatric rehabilitation is provided primarily in the home or in community based settings where skills must be practiced.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:15:10. Nonreimbursable services. Nonreimbursable services include:

(1) Vocational services;

(2) Academic educational services;
(3) Services which are solely recreational in nature;
(4) Services with individuals other than eligible consumers;
(5) Services delivered by telephone; and
(6) Services provided in an institute for mental disease.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(3).
Law Implemented: SDCL 27A-5-1.

46:20:15:11. Co-payments. Co-payments may not be charged for any IMPACT services.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(2).
Law Implemented: SDCL 27A-5-1.

46:20:15:12. Refusal to serve a consumer with a severe and persistent mental illness -- Alternate provider. The division has the authority to reduce the contract of the refusing provider in order to purchase necessary services from an alternative provider. An IMPACT program may not refuse services to any consumer with a severe and persistent mental illness unless:

(1) The IMPACT program provides written notice of the refusal to the division within 72 hours of its refusal;

(2) The IMPACT program offers emergency services to the consumer until such time as the consumer can be relocated to another service area or alternative services are arranged; and

(3) The IMPACT program arranges for appropriate mental health services with another provider to serve the consumer.

Source: 29 SDR 80, effective December 10, 2002.
General Authority: SDCL 27A-5-1(5).
Law Implemented: SDCL 27A-5-1.

46:20:15:13. Discharge criteria. Discharge from the IMPACT program may occur when:

(1) The consumer moves outside of the geographic area of the IMPACT program. In such cases, whenever possible, the IMPACT program must arrange for transfer of mental health service responsibility to a provider within the catchment area where the consumer is moving;

(2) The consumer demonstrates an ability to function in all major life areas such as work, socializing, and self-care, without requiring assistance from the program, or may benefit from a less intensive level of services; or

(3) The consumer refuses to participate in IMPACT program services for more than three consecutive months. During the three month period the IMPACT program

shall keep the consumer's case open and make reasonable attempts to contact the consumer. If refusal continues, or contact cannot be made within three months, discharge may be pursued.

Source: 29 SDR 80, effective December 10, 2002.

General Authority: SDCL 27A-5-1(5).

Law Implemented: SDCL 27A-5-1.

46:20:15:14. Discharge documentation. A consumer receiving IMPACT services may not be discharged from the program without prior notification, documentation, and approval by the division. Documentation to the division must include:

(1) Reason for discharge;

(2) Consumer's status and condition at discharge;

(3) Written evaluation summary of the progress toward the goals set forth in the case service plan;

(4) A plan for care and follow-up developed in conjunction with the consumer, if applicable; and

(5) Signature of the clinical supervisor.

Source: 29 SDR 80, effective December 10, 2002.

General Authority: SDCL 27A-5-1(5).

Law Implemented: SDCL 27A-5-1.

Intensive Family Services Program

OVERVIEW

Intensive Family Services, (IFS). IFS is provided jointly by the Department of Corrections, Department of Labor, Department of Human Services, and the Department of Social Services. This pre-aftercare program is a multi-departmental effort of various state agencies to provide an opportunity to families of youths who are placed under the jurisdiction of the Department of Corrections to address issues and access needed services to allow their children to return to their homes with the greatest opportunity for success. Discharge planning should begin as soon as youths are placed in residential settings. All departments agree that because of the limited time available to work with families before their child returns home, every effort will be expended to respond quickly to referrals by assessing the families' needs and obtaining needed services on a timely basis. Each aspect of IFS has suggested timelines, which will be followed as closely as possible. Service providers must provide intensive services in order to complete goals in the allotted amount of time. The purposes of Intensive Family Services are:

A. To assess the ability of the parent(s) and family to serve as an appropriate placement resource for the youth upon release;

B. To reduce or eliminate issues present within the family that may contribute to or allow delinquent behaviors;

C. To promote the successful reintegration of the youth into their family upon their return or placement in the home upon release; and

D. To reduce the likelihood of recidivism of the youth to the Correction System through improved family functioning.

REFERRAL PROCESS

As a part of the comprehensive assessment done by the IFS social workers, the social worker will complete a Mental Health Initial Screen on the family. The screen will be an objective way of deciding which families need referral to mental health services. The social worker will follow the instructions on the screening form to decide whether a family needs to be referred for further assessment by mental health staff. In the event families are currently receiving services from the community mental health center, the social worker should obtain a release of information to the mental health center, for the purpose of discussing current services as well as the appropriateness of the youth returning home. If after discussing current services, it is apparent a referral needs to be made the screening form is e-mailed to the Division of Mental Health. The Division of Mental Health will provide the social worker with a contact person at the local Community Mental Health Center, in an effort to get the family started with mental health services. The social worker should give the contact person a copy of the family's completed assessment form. If families are reluctant to pursue this service, they should be encouraged to go through the assessment process at the very least. The assessment is

free of charge and families are not obligating themselves beyond the completion of the assessment.

The community mental health centers will provide services to eligible families based upon the agency's assessment of needs. They will complete an evaluation of the family within ten working days of receiving the referral from the Division of Mental Health. If an evaluation has been completed within the past six months, the mental health center will not need to complete a new one. An update of the previous evaluation should suffice. The mental health services being offered to IFS families will specifically address issues that may negatively affect reunification of the absent youth and his/her family.

PRINCIPLES AND METHODS

Adhere to requirements outlined in ARSD 46:20:13:02, 46:20:13:03, 46:20:13:05 – 46:20:13:07 and the SED Children's Program Attachment 3, Part II. Part II; B and H of Attachment 3 will not apply, as youth in the IFS Program are not in the community. In addition, the requirement that the child participate in the child/family team will also not apply, due to accessibility of the child.

CLINICAL RECORD

A. Needs Assessment

The meeting can take place in the setting most clinically appropriate, as agreed upon by the family. The needs assessment must be completed within ten (10) days of receipt of the referral.

2. Content. This assessment will help determine the nature and extent of the family's problems as well as identify strengths of the family through a systematic appraisal and documentation in the case file of the following:
   a. Identifying information;
   b. Presenting problems/chief complaint;
   c. Treatment history including previous treatment, psychiatric hospitalization, psychotropic and other medications, physical illnesses, hospitalizations;
   d. Family history including family relationships and dynamics, family psychiatric history;
   e. Educational history/needs;
   f. Alcohol/drug abuse issues;
   g. Legal issues;
   h. Social needs;
   i. Safety needs, in regards to physical acting out or health conditions;
   j. Vocational and financial history/needs; and
   k. Date, staff signature, title.
3. Discussion. During the needs assessment phase, the therapist will discuss the following with the family:
   a. Describe services available to the child and family under Intensive Family Services (IFS);
   b. Answer any questions regarding the processes and benefits of mental health services provided to family members;

c. Describe the roles of the case manager and therapist; and
d. Describe the agencies procedure for accessing crisis intervention services.

B. Family Service Plan

A strength based, comprehensive, family service plan must be developed which includes a clear statement of the problem(s) and goals.

1. Requirements. The therapist of case manager and the family will develop the family service plan. Input from the Department of Social Services, social worker and the Juvenile Correction Agent will be utilized in development of the plan. The family service plan needs to be completed within 21 days of intake. The plan will be contained in the client file and a copy provided to the parents.

C. Progress Notes

Notes that describe the family's progress in achieving goals shall be documented in the families clinical record for each billable service provided.

1. Individual therapy notes. At a minimum, progress notes must correlate with the goals specified on the case service plan, substantiate all services provided, and include:
   a. Information identifying the family including name and CID number;
   b. The date and location of the service provided;
   c. The MIS service activity code or title describing service code
   d. The units of service;
   e. The staff providing service;
   f. A brief assessment of the parent(s)/family's functioning; and progress towards service plan goals
   g. A description of what will happen next in treatment.
2. Group therapy notes. One progress note can be used per group therapy session if the note includes the necessary information for each parent participating. This information includes:
   a. Individual parent's level of participation; and
   b. Progress toward achieving goals noted on the family service plan.

ADMISSION AND DISCHARGE INFORMATION

A. Eligibility Criteria

Families served by IFS are exempt from the eligibility criteria in ARSD 46:20:13:04. All families referred and deemed appropriate are eligible.

B. Discharge Criteria.

Discharges from the IFS Program shall occur when:

1. The child is released from placement and returns home. Services may continue under the Children's SED Program if eligibility criteria is met, or under non-SED outpatient.
2. The CMHC is notified by the Department of Social Services or the Department of Corrections that the child's home has been deemed an inappropriate placement option, and the child will not be returning.

3. The family is consistently non-compliant with services. The Department of Social Services Social Worker and the Juvenile Correction Agent must be notified of the non-compliance and resulting termination.
4. The family successfully accomplishes goals outlined in the case service plan.

C. Documentation

Upon discharge from the IFS Program, the community mental health center must complete the outcome section of Division of Mental Health form SED-351 and send/fax it to the DMH in Pierre.

BILLING INFORMATION

A. Billable Services

Activities include face-to-face and collateral contacts for the purpose of providing comprehensive mental health treatment for families. Full mental health services contracted through the Department of Human Services must be provided throughout the entire contract period. All information submitted must contain parent/family's name and CID number. One unit of service is fifteen (15) minutes in duration. Billable services include:

1. Individual and group therapy;
2. Family education/support/therapy specifically relating to the family's difficulties;
3. Crisis intervention;
4. Evaluations; and
5. Case management services.

B. Non-Billable Services

Non-billable services include but are not limited to vocational services, educational services, services that are solely recreational in nature, and services for individuals other than eligible family.

C. Cost Centers

Examples of allowable costs are staff salaries and benefits, rent, utilities, building depreciation, maintenance, insurance, capital assets depreciation, supplies and travel. Providers shall participate in the planning, development, and implementation of coordinated transportation efforts. Failure to participate may result in dis-allowance of travel costs.

D. Means Testing

Means testing is waived for the Intensive Family Services Program.

E. Deadline for Billing Submission

Billing for services provided during this contract period must be submitted by June 11, 2004. Services billed after that date will not be paid.

Serenity Hills

Concurrent Mental Health/Chemical Dependency Services

OVERVIEW

Serenity Hills is a custodial care facility for adults who are diagnosed with a mental health disorder and a substance abuse disorder. This program uses a multidisciplinary "integrated" model that combines both mental health and substance abuse treatment within a single, unified, and comprehensive custodial care program. The Serenity Hills Program places an emphasis on the chronic disease model of chemical dependency. This model includes abstinence, acceptance of the chronic incurable nature of chemical dependency, and utilization of self-help groups for support and maintenance. It also includes psychological interventions targeting psychological conditions and chemical dependency issues, especially those that are likely to precipitate relapse or perpetuate the addictive process, and which interfere with the client's ability to function independently.

PRINCIPLES AND METHODS

The Serenity Hills Dual Diagnosis Program must meet all of the requirements in the Administrative Rules (Chapter 46:05:20) from the Division of Alcohol and Drug Abuse for "Clinically-Managed Low-Intensity Residential Treatment Program". Additionally, the program provides psychological evaluations, medication management, and routine psycho-education by a psychiatrist, licensed psychologist, registered nurse, and counseling staff.

A. Primary Clinical Services

1. Screening/Evaluation.
2. Group and/or individual therapy at least four hours weekly;
3. Psycho-education at least one hour weekly;
4. AA meetings at least two times per week;
5. Medication management as needed;
6. Family therapy, as clinically appropriate; and

B. Adjunctive Services

1. Recreational therapy at least once weekly;
2. Physical exercise at least four times weekly;
3. Coordination with Job Service/Vocational Rehabilitation as needed;
4. Employer conferences as needed;
5. Referral to the Human Service Agency Aftercare Group; and
6. Collateral contacts.

C. Case Management

1. Admissions conference upon admission;
2. Orientation within 48 hours of admission;
3. Psychological evaluation within 9 days of admission;
4. Needs assessment within 9 days of admission;
5. Treatment plan development (with consumer's involvement) within 10 days of admission;
6. Treatment plan reviews every 14 days;
7. Discharge planning conference within 3 days from discharge (discharge planning occurs throughout the course of treatment); and
8. Medical discharge planning conference within 3 days from discharge.

D. Crisis Assessment and Intervention

Serenity Hills will have staff in the residential facility 24 hours per day, 7 days per week to provide intervention and crisis services. Medical staff including EMT's, RN's and a paramedic will be available for detoxification, assistance with psychotropic medication management, and assistance with other health needs.

E. Symptom Assessment and Management

Symptom assessment and management, supportive counseling and psychotherapy, when clinically indicated, will be provided to help the consumers cope with and gain mastery over symptoms and disabilities in the context of daily living. This shall include:

1. Ongoing assessment of the consumer's mental illness symptoms and the consumer's response to treatment;
2. Education, when appropriate, of the consumer regarding his/her illness and the effects and side effects of medications prescribed to regulate it;
3. Symptom management efforts directed to helping each consumer identify symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects; and
4. Provide both on a planned and "as needed" basis, psychological support to consumers to help them accomplish their independent living goals and to cope with the stresses of day-to-day living.

F. Medication Prescription, Administration, Monitoring and Documentation

1. The psychiatrist, physician, physician assistant, or certified nurse practitioner shall:
   a. Assess each consumer's mental illness symptoms and behavior and prescribe appropriate medication;
   b. Regularly review and document the consumer's mental illness symptoms as well as his/her response to prescribed medication treatment; and
   c. Monitor, treat and document any medication side effects.
   d. The services provided by a psychiatrist, physician, physician assistant, or certified nurse practitioner shall be billed at a rate separate from other Serenity Hills services.
2. Only staff who have completed a medication administration training

course following the guidelines of ARSD 46:20:12:04 (4) (from the Division of Mental Health) may provide the following services:

a. Assist with administration of prescription and nonprescription medications prescribed by a psychiatrist, physician, physician's assistant, or certified nurse practitioner for consumers who are incapable of self-administration; and
b. Instruct in the act of self-administration of prescription and nonprescription medications prescribed for self-administration by a psychiatrist, physician, physician's assistant, or certified nurse practitioner;
c. Provide for security and storage of medications, maintain appropriate supplies (i.e., daily supplies, long-term injectable, and longer-term supplies) and set aside a private designated area for set up of medications by the medical staff; and
d. Administer medications to consumers.

G. Direct Assistance

Serenity Hills staff will provide direct assistance to ensure that the consumer obtains the basic necessities of daily life, and performs basic daily living activities. This assistance includes:

1. Medical, dental and vision services;
2. Support in helping consumers find and maintain employment in community-based job sites;
3. Budgeting and financial support;
4. Linking to social service agencies;
5. Legal and advocacy services;
6. Using community transportation, as appropriate; and
7. Locating, financing and maintaining safe, clean, affordable housing when discharge is planned.

H. Development of Psychosocial Skills

Serenity Hills staff shall assist in the development of psychosocial skills which include, but are not necessarily limited to:

1. Helping individual consumers develop social skills;
2. Helping individual consumers develop skills in managing distressing emotional states; and
3. Helping individual consumers develop self-confidence and self-esteem.

I. Family Participation

As clinically appropriate, Serenity Hills staff shall encourage the active participation of family and/or supportive social network, by providing the following:

1. Education about the consumer's illness and their role in the therapeutic process;
2. Supportive family counseling related to the consumer and issues surrounding his/her illness; and
3. Intervention to resolve conflict.

J. Staff Qualifications
(See 46:05:05:03 – 46:05:05:12)

K. Hours of Operation
(See 46:05:20:09)

L. Grievance Process
(See 46:05:07:05)

M. Client Rights
(See 46:05:07:01)

CONSUMER CASE RECORDS
(See 46:05:09)

ADMISSION/DISCHARGE INFORMATION

A. Eligibility Criteria

Enrollment in the Serenity Hills Program for consumers being partially funded by the Division of Mental Health will be limited to consumers who meet the following:

1. **Has a severe mental disability.** The individual's emotional, behavioral or psychological disorder has resulted in at least one of the following:
   a. Has undergone psychiatric and/or chemical dependency treatment (e.g., emergency services, alternative residential living, inpatient hospitalization or outpatient care and has a psychiatric Axis I and/or Axis II diagnosis.
   b. A single episode of psychiatric hospitalization with an Axis I and/or Axis II diagnosis.
   c. Has ever been maintained on psychotropic medication.
   d. Frequent crisis contacts with mental health/or chemical dependency/ or judicial systems for more than six months and has not been successful in traditional chemical dependency treatment.
2. **Has impaired role functioning.** The individual's emotional, behavioral or Psychological disorder has resulted in at least three of the following:
   a. Is unemployed or has markedly limited job skills and/or poor work history.
   b. Is employed in a sheltered setting.
   c. Is unable to perform basic living skills without assistance.
   d. Exhibits inappropriate social behavior which results in concern by the community and/or requests for mental health/chemical dependency services by the judicial/legal systems.
   e. Inability to procure appropriate public support services without assistance.
   f. Requires public assistance for out of inpatient care maintenance.
   g. Lack of positive social support systems in a natural environment (e.g., no close friends, live alone, isolated).

The above criteria are included on a form entitled "Notice of Service to New Serenity Hills Consumer". This form will need to be approved by the Division of Alcohol and Drug Abuse and the Division of Mental Health prior to a

consumer being admitted into the program. After a referral is submitted to the Division of Alcohol and Drug Abuse, the form will be completed by staff of the DADA and DMH for approval or disapproval. The form and referral information shall then be faxed to the Serenity Hills Program Director, who will make appropriate arrangements for admission into the program. If a consumer is currently a resident of Serenity Hills and it is felt that he/she meets the above criteria, then the Serenity Hills Program Director will complete the "Notice of Service to New Serenity Hills Consumer" and fax this form to the DADA and DMH for approval or disapproval.

B. Discharge

(See 46:05:20:10)

BILLABLE SERVICES

A. Documentation

Documentation of persons residing within the facility must be maintained to verify services for which reimbursement is claimed. All information submitted must contain consumer's name, CID number and social security number.

B. Unit Size

A unit of service will be one (1) day. This includes all services provided, other than those provided by a psychiatrist/CNP/physician/physician assistant.

C. Billable psychiatrist/CNP/physician/physician assistant services include:

a. Symptom assessment and monitoring;
b. Prescription of medications/monitoring and treatment of medication side effects; and
c. Medical/psychiatric evaluations.

D. Cost Centers

Examples of allowable costs are staff salaries and benefits, rent, utilities, building depreciation, maintenance, insurance, capital assets depreciation, supplies and travel. Providers shall participate in the planning, development, and implementation of coordinated transportation efforts. Failure to participate may result in disallowance of travel costs.

E. Means Testing

The Division of Mental Health will only participate in payment of services to individuals that are determined financially needy as outlined in Policy Memorandum 01-04.

F. Deadline for Billing Submission

Billing for services provided during this contract period must be submitted by June 11, 2004. Services billed after this date will not be paid.

BYLAWS
MENTAL HEALTH PLANNING AND COORDINATION ADVISORY COUNCIL - SOUTH DAKOTA

(AS AMENDED AND APPROVED ON AUGUST 2, 2001)

ARTICLE I: NAME

The name of this organization shall be Mental Health Planning and Coordination Advisory Council, hereinafter also referred to as "Mental Health Advisory Council" (MHAC) and "Advisory Council" (AC).

ARTICLE II: AUTHORITY

The legal authority for the establishment and administration of the Mental Health Advisory Council rests in Section 1914 (c) of the Public Health Service Act (42 U.S.C. 30x-4). As Amended.

ARTICLE III: PURPOSE

Purpose of the Mental Health Advisory Council shall be to provide a leadership role in the development and implementation of the state comprehensive mental health services plan and to advocate that persons served by the mental health delivery system achieve their highest attainable degree of independence, productivity and integration into community life and receive quality health services.

ARTICLE IV: ACTIVITIES

The Mental Health Advisory Council shall meet at least quarterly unless otherwise determined by the council and its activities shall include, but not be limited to, the following:

Section 1. Advising. The Mental Health Advisory Council shall advise the Department of Human Services on all aspects of the development, implementation and modification of any necessary state or federal comprehensive mental health plans including funding, coordination of services, quality issues, policy related matters and matters relating to the Human Services Center and community mental health centers.

Section 2. Monitoring and Evaluating. The Mental Health Advisory Council shall, on a continuing basis review, monitor and evaluate the implementation of the state comprehensive mental health services plan and the mental health service system in South Dakota and provide for methods to evaluate the quality of that service network.

Section 3. Reporting. The Mental Health Advisory Council shall transmit its comments and reports to the Governor of South Dakota and the Secretary of the US Department of Health and Human Services as required by the state and federal statutes governing its activities.

Section 4. Coordinating. The Mental Health Advisory Council shall advise the Department of Human Services to achieve greater coordination of planning and service delivery efforts among the various agencies involved in the mental health service delivery network and shall continually work for needed system expansion and highest quality service.

Section 5. Advocacy. The Mental Health Advisory Council shall serve as an advocate to all individuals needing mental health services within the state.

ARTICLE V: MEMBERSHIP

Section 1. Appointment. Members of the Mental Health Advisory Council shall be appointed by the Governor from among the residents of the state with consideration for reasonable geographic representation from the entire state.

Section 2. Composition and terms. The Mental Health Advisory Council membership and terms of membership shall be in accordance with requirements set out in Section 1914 (c) of the Public Health Service Act (42 U.S.C. 30x-4).

The council shall consist of the following who shall be appointed by and serve at the pleasure of the Governor:

1. The director of Division of Mental Health, or designee;
2. The director of the Office of Special Education, or designee;
3. The director of the Division of Rehabilitation Services, or designee;
4. The State Court Administrator, or designee;
5. The executive director of the S.D. Housing Development Authority, or designee;
6. The secretary of the Department of Social Services, or designee;
7. A representative of Indian Health Services, whose term shall expire June 30, 2003;
8. A qualified mental health professional who provides direct services to adults with severe and persistent mental illness in an approved community mental health center (not a center director), or the Human Services Center, whose term shall expire June 30, 2004;
9. The administrator of the South Dakota Human Services Center, or designee;
10. A representative of the South Dakota Council of Mental Health Centers, whose term shall expire June 30, 2005;
11. The secretary of the Department of Corrections, or designee;

12. A qualified mental health professional who provides direct services to children with serious emotional disturbances in an approved community mental health center (not a center director), or the Human Services Center, whose term shall expire June 30, 2003;
13. A family representative of a child (under eighteen years) with a serious emotional disturbance, whose term shall expire June 30, 2003;
14. A family representative of a child (under eighteen years) with a serious emotional disturbance, whose term shall expire June 30, 2004;
15. A family representative of a child (under eighteen years) with a serious emotional disturbance, whose term shall expire June 30, 2005;
16. A family representative of an adult (eighteen years or over) severely mentally ill individual, whose term shall expire June 30, 2004;
17. A representative of a statewide family support and advocacy group, whose term shall expire June 30, 2005;
18. A primary consumer of mental health services with preference for an adolescent that is at least 15 years of age and under 18 years of age at the time of appointment, whose term shall expire June 30, 2003;
19. A primary consumer of mental health services, whose term shall expire June 30, 2003;
20. A primary consumer of mental health services, whose term shall expire June 30, 2004;
21. A primary consumer of mental health services, whose term shall expire June 30, 2005;
22. A representative of a statewide mental health consumer organization, whose term shall expire June 30, 2004;
23. The executive director of the South Dakota Advocacy Services, or designee;
24. A public educator or administrator, whose term shall expire June 30, 2005; and
25. A family representative of an adult (sixty-two years of age or over) severely mentally ill individual, whose term shall expire June 30, 2003;
26. A family representative of an adult (eighteen years or over) severely mentally ill individual, whose term shall expire June 30, 2005.

Primary consumers and family representatives must be or represent current or prior recipients of public mental health services. For the three positions for a family representative of a child (under eighteen years) with a serious emotional disturbance, the preference is to have representation, at the time of appointment, of children in early childhood (under 6 years of age), elementary (ages 6-12 years of age), and high school (ages 13 to 17 years of age). Future terms of those members with established terms shall be three years. Members may not be appointed for more than two, consecutive three-year terms.

Section 3. Attendance. Council members, with the exception of those specifically mentioned in the Bylaws, may not designate persons to attend meetings or vote on their behalf.

Those members allowed to designate and who choose to do so shall designate in writing a representative who will attend in the appointed member's absence and shall convey the name of the designee to the Department of Human Services. A designee shall be considered a council member in all respects until a change in status is conveyed to the Department of Human Services in writing by the person who designated or his successor.

Council members and designees shall notify the Council staff when they are unable to attend a meeting. If a Council member has more than two absences per Council year, the Governor's Office shall be notified and asked to contact the appointee concerning that appointee's willingness to continue to serve on the Advisory Council. If a designee has more than two consecutive absences the person who appointed the designee shall be notified. The Council Year shall be from July 1 to June 30 of the following year.

Section 4. Resignation. Any member desiring to resign from the Council shall submit his resignation to the Governor's Office and send a copy of the letter to the Department of

Human Services and the Council Chairperson. This individual will remain a member of the Council until such time as the Governor's Office is able to fill the vacancy.

Section 5. Financial Compensation. Members shall serve on the Council without compensation, except that members and designees shall be reimbursed for travel expenses as set forth in Title 5 of the Administrative Rules of South Dakota. Reimbursement for travel expenses shall be provided for a person attending with council members who require such assistance to participate. Reimbursement for other expenses, e.g., attendant care services, interpretive services, telephone, postage, etc., necessary to allow for participation and fulfillment of council responsibilities by council members shall be coordinated with and approved by the Department of Human Services.

ARTICLE VI: OFFICERS

Section 1. Positions. The officers of the Council shall include a Chairperson and Vice-Chairperson. At no time may the positions of Chairperson and Vice-Chairperson be simultaneously held by persons who provide mental health services, or represent an organization that provides mental health services or represent an organization whose members provide mental health services.

Section 2. Duties.

(a) Chairperson. The Chairperson shall preside at all meetings of the Council. The Chairperson, in cooperation with the Council, Council staff and the

Department of Human Services shall schedule all meetings of the Council and perform all such duties relative to the office. The Chairperson in furthering the purpose and activities of the Council may represent the Council in dealings with other organizations and at public meetings and conferences, or may designate a council member as the Chairperson's representative.

(b) Vice-Chairperson. The Vice-Chairperson shall act as Chairperson in the absence of the Chairperson. In the event of the resignation, incapacity, or death of the chairperson, the Vice-Chairperson shall serve as Chairperson until the council elects a new Chairperson. the Vice-chairperson shall perform other duties as may be assigned by the Chairperson.

Section 3. Nominations. Nominations for Council officers shall be made from the floor.

Section 4. Elections. The Council officers shall be elected by Advisory Council membership. Elections shall be held during the last quarter of the council year. Election to office shall be by a majority of members attending and voting.

Section 5. Eligibility to Hold Offices. Officers shall be selected from those members who are not subject to the absence notification provision of Article V, Section 3.

Section 6. Terms. The term of office for the Chairperson and the Vice-Chairperson shall be two years. Members may hold the same office for more than one term provided there is an interval of two years between terms.

Section 7. Vacancies. Vacancies in elected offices shall be filled by a majority vote of the members in attendance at the next Council meeting after the vacancy occurs. Officers so elected shall serve for the remainder of the vacated term and shall be eligible for election to that office for the next full term.

ARTICLE VII: MEETINGS

Section 1. Schedule.

(a) Regular. The Council shall meet at least quarterly.

(b) Special. Special meetings of the Council may be called by the Chairperson or by the Chairperson at the request of 10 council members.

Notice of special meetings shall be made to all Council members not less than 10 days prior to the meeting stating the time, date, location and purpose of the meeting. No other business shall be transacted at a special meeting.

Section 2. Quorum. A quorum for an Advisory Council meeting shall be fifty percent (50%) of the appointed membership.

Section 3. Agenda and Supporting Materials. An agenda and supporting materials for a regularly scheduled meeting shall be distributed 10 days in advance of the meeting. Requests for items to be included on the agenda shall be submitted to the Chairperson at least fifteen (15) days prior to the meeting. The Chairperson shall coordinate agenda development and distribution with Council staff. Agenda items may be added at any meeting with the approval of a majority of the members attending.

Section 4. Open Meetings Law. All meetings shall be open to the public in accordance with the state open meetings law, set out at South Dakota Codified Laws 1-25-1.

Section 5. Voting. Voting shall be by advisory council members present. Voting by proxy shall not be permitted. A person designated as provided for in Article V is not a proxy.

Section 6. Public Notice. Public notice of all meetings shall be given by posting the agenda at the Division of Mental Health at least 24 hours prior to any meeting as set forth in SDCL 1-25-1.1.

ARTICLE VIII: COMMITTEES

The Council shall have necessary standing committees to adequately conduct the affairs of the Council. These standing committees shall include a children's services sub-committee and an adult services sub-committee. The standing committees may include members that are not members of the Mental Health Planning and Coordination Advisory Council.

Committees to be created under this Article shall be approved by a majority of the Council membership at any regular or special meeting.

Committees shall represent the Council when authorized to do so by the Council or Chairperson. Committee members shall be appointed from the Council membership by the Chairperson taking into consideration requests by the Council membership to participate in specific committees.

The Chairperson may appoint ad hoc committee members who are not council members provided however that non-council members shall not participate in council voting.

ARTICLE IX: PARLIAMENTARY AUTHORITY

Council meetings shall be conducted in accordance with the rules contained in the current edition of *Roberts Rules of Order Newly Revised* in all cases in which they are applicable and in which they are not inconsistent with these bylaws and any special rules the Council may adopt.

ARTICLE X: AMENDMENT OF BYLAWS

These Council bylaws may be amended at any meeting of the Council by a majority vote of the appointed Council membership in attendance provided the amendment has been distributed to all Council members at least 10 days prior to the date of the meeting.

ARTICLE XI: CONFLICT OF INTEREST

It shall not be considered a conflict of interest for any individual or an employee, officer, or director of any firm, corporation, department, facility or agency to serve as a member of the Council provided such member shall abstain from action and voting by the Council in matters where the member may receive a direct personal financial benefit from a contract or grant awarded by the Council.

ARTICLE XII: DESIGNATED STATE AGENCY

The Advisory Council shall be assigned to the Department of Human Services.

ARTICLE XIII: COUNCIL STAFF

Technical assistance and staff support shall be provided to the Mental Health Advisory Council by the Department of Human Services.

Role of the Mental Health Planning and Coordination Advisory Council

27A-3-1.1. Mental Health Planning and Coordination Advisory Council created -- Appointments. There is created the Mental Health Planning and Coordination Advisory Council which shall be appointed by and serve at the pleasure of the Governor. The council shall be assigned to the Department of Human Services. Technical assistance and staff support shall be provided to the council by the Department of Human Services. The secretary of human services shall be responsible for the coordination of activities between the advisory council and the Department of Human Services.

27A-3-1.2. Appointment of council members -- Three-year terms. Repealed by SL 2002, ch 134, § 1.

27A-3-1.3. Functions of council. The council shall advise the Department of Human Services in developing and in the modification of any necessary state or federal mental health plans, and shall advise the department in influencing and achieving greater coordination of planning and service delivery efforts among the various federal, state, local, or private agencies involved in the mental health service delivery network, and shall continually work for needed program and service expansion and achievement of the highest possible quality service. The council shall serve as an advocate for all individuals needing mental health services within the state.

27A-3-1.4. Additional functions of council. In addition to the council's functions provided in § 27A-3-1.3 the council shall advise the Department of Human Services on policy related matters and on matters related to the allocation of federal and state funds to the mental health centers in the state and the South Dakota Human Services Center, on matters concerning regulation, staff requirements, administration, audit and record keeping, and services to be provided by mental health centers and the South Dakota Human Services Center. The council shall further advise the department upon matters concerning the department's duties as provided in this chapter.

27A-3-1.5. Meetings -- Annual report. The Mental Health Planning and Coordination Advisory Council, created by § 27A-3-1.1, shall meet at least quarterly unless otherwise determined by the council. The council shall prepare an annual written report to the Governor on or by December first of each year.

PRIORITY ONE: Create an Environment for Change						
Strategy(-ies)	**Action(s)**	**Manager[1]**	**Implementer[2]**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
Strategy 1.1 - *Changing the paradigm*	Action 1.1.1 Division of Mental Health, Division of Alcohol Drug Abuse, and the Human Services Center will develop a strategic plan to address Co-Occurring Disorders in a single, comprehensive department model.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon, Gib Sudbeck, Cory Nelson	Strategic plan	DMH, DADA, HSC will hold planning meeting Develop draft plan	08/01/04 01/01/05
	Action 1.1.2 Research the feasibility of combining the CD and MH Advisory Councils.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon, Gib Sudbeck, Jim Hagel, Marla Bull Bear	Combined councils	Research feasibility with in state law and at federal level Draft statutory and by-laws changes Seek SAMHSA approval Change effective	08/01/04 10/01/04 09/01/04 07/01/05
	Action 1.1.3 Define what "No Wrong Door" means for co-occurring disorders in South Dakota and then establish it as the standard of care for South Dakotans seeking services at all entry points.	Betty Oldenkamp/ Brooke Templeton	Terry Dosch	Providers will adopt "No Wrong Door"	Define concept of "No Wrong Door" Identify agencies/entities affected Communicate "No Wrong Door" message to agencies and consumers	08/01/04 08/01/04 01/01/05 and on-going

Strategy 1.2 - *Building the political will*	Action 1.2.1 Seek input from consumers, family members, advocacy groups, tribal representation, providers and policy makers to participate in the strategic plan for comprehensive service delivery.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon, Gib Sudbeck, Cory Nelson	Plan reflects stakeholder input	ID stakeholders at initial planning meeting Solicit input on plan	08/01/04 01/01/05
	Action 1.2.2 Utilize the key stakeholders to educate and gain support of other interested parties.	Betty Oldenkamp/ Brooke Templeton	Strategic Planning Team	Plan has wide-spread support	Stakeholders educate respective constituent groups Stakeholders provide feedback to planning team	01/01/05 01/01/05
Strategy 1.3 - *Communicating the moral imperative*	Action 1.3.1 Convince the Governor and Legislators that this issue is a moral imperative. "Have you ever wondered?" or the "Ever Wonder?" campaign.	Deb Bowman/ Betty Oldenkamp	Betty Oldenkamp	Governor's approval to move forward Increase understanding of co-occurring disorders	Meet with Governor (done 5/17/04) Meet with Health and Human Services Committee	06/01/04 02/01/05
	Action 1.3.2 Develop professional campaign for moral imperative. "Have you ever wondered?" or the "Ever Wonder?" campaign	Betty Oldenkamp/ Brooke Templeton	Policy Academy Team	Increase understanding of co-occurring disorders	Define target of campaign Refine message Develop "package"	08/01/04 11/01/04 01/01/05

Progress to Date	Barriers and/or Situational Changes	Immediate Next Steps (including potential technical assistance needs)
Met with Governor Follow-up meeting to complete action plan	Many competing priorities	Planning meeting Request technical assistance from Christina Dye (Arizona)

[1] The Manager is the individual responsible for coordinating each action.

[2] The Implementer is the individual (or entity) responsible for carrying-out each action.

PRIORITY TWO: Build a Comprehensive System (COD)						
Strategy(-ies)	**Action(s)**	**Manager**	**Implementer**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
Strategy 2.1 - *Creating a competent workforce*	Action 2.1.1 Develop training plan to support a competent workforce including case managers and para-professionals.	Betty Oldenkamp/ Brooke Templeton	Terry Dosch	Existing staff are cross-trained	Identify existing training models Adopt training model Joint training of MH/CD professionals	10/01/04 03/01/05 09/01/05
	Action 2.1.2 Establish an infrastructure for preparation of providers.	Betty Oldenkamp/ Brooke Templeton	Terry Dosch	Professionals leaving the higher education system will be ready to work with people with co-occurring disorders.	Identify core competencies necessary to provide co-occurring services Develop Certification/Licensure standards for co-occurring disorders Development of COD curriculum for MH/CD professionals for both state and tribal universities	10/01/04 07/01/07 09/01/07

Strategy 2.2 - *Developing a continuum of integrated care*	Action 2.2.1 Endorse models of individualized services for people with co-occurring disorders.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon/ Gib Sudbeck	A responsive, comprehensive system of prevention and treatment	Identify components of integrated individualized models of treatment Identify the community-based services required including case management, peer support and family involvement Develop missing service components Demonstrate models Evaluate demonstrations	10/01/04 10/01/04 07/01/05 07/01/06 10/01/06 and ongoing
	Action 2.2.2 Implement prevention models for people with co-occurring disorders.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon/ Gib Sudbeck	A responsive, comprehensive system of prevention and treatment services	ID target populations ID prevention models with demonstrated effectiveness for target populations Demonstrate models Evaluate demonstrations	10/01/04 07/01/05 07/01/06 10/01/06 and on-going

Strategy 2.3 - *Establishing a core assessment process*	Action 2.3.1 Implement a uniform multi-dimensional screening and assessment tool.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon, Gib Sudbeck, Terry Dosch, Randy Allen, Marla Bull Bear	People with co-occurring disorders are appropriately identified	Adopt an integrated screening process for all entry points to services Distribute tool and train providers Adopt an assessment tool(s) Distribute tool and train providers Promote use through incentives, reimbursement and/or accreditation	07/01/06 01/01/07 07/01/06 01/01/07 01/01/07

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**
CO-SIG application Work on provider readiness assessment	Barriers will be identified upon completion of provider readiness assessment	Summer intern to conduct research on training models, prevention, and treatment models

PRIORITY THREE: Ensure Quality Outcomes						
Strategy(-ies)	**Action(s)**	**Manager**	**Implementer**	**Expected Outcomes**	**Benchmarks**	**Completion Date (Estimated)**
Strategy 3.1 - *Designing a system of accountability*	Action 3.1.1 Establish and operationalize principles of care.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon, Gib Sudbeck, Terry Dosch, Cory Nelson	Services will be guided by the principles of care and outcomes	Research and establish principles of care Adopt/implement measurable outcomes for individuals Adopt/implement measurable outcomes for the system(s) Ensure MIS supports COD outcome measures with on-going evaluation	10/01/04 07/01/05 07/01/05 07/01/05
	Action 3.1.2 Align regulatory policy with new practices.	Betty Oldenkamp/ Brooke Templeton	Kim Malsam-Rysdon/ Gib Sudbeck	Regulatory barriers to co-occurring services will be removed	Modify service contracts/agreements for demonstrations Monitor allocation, expenditures and performance Modify service agreements Revise ARSD/SDCL	07/01/05 07/01/05 and on-going 07/01/06 07/01/07

Strategy 3.2 - *Funding a system of integrated care*	Action 3.2.1 Align funding policies and levels of funding to support an integrated system of care.	Betty Oldenkamp/ Brooke Templeton	Dan Lusk, Kim Malsam-Rysdon, Gib Sudbeck, Terry Dosch, Cory Nelson	Full funding alignment with co-occurring services	Review existing fund sources Identify funding for integrated COD services Realignment of existing funds Develop reimbursement policy linked to outcomes, modeled rates, billing codes and claims process. Identify and garner new fund sources, i.e. Medicaid Develop framework for incentives	10/01/04 10/01/04 07/01/05 07/01/05 07/01/06 07/01/07

Progress to Date	**Barriers and/or Situational Changes**	**Immediate Next Steps (including potential technical assistance needs)**
CO-SIG application	Perceived ownership of funding Resistance to expansion of Medicaid services/eligibility. Current block grant requirements	Summer intern to research principles of care

Department of Human Services
Division of Mental Health
Room and Board

I. OVERVIEW

Residential housing provides room and board for individuals ages 18 and older who have a severe and persistent mental illness and who, due to their illness, are unable to function in an independent living arrangement.

II. PRINCIPLES AND METHODS

Individuals living in Residential Housing will be provided, as appropriate, the broad range of services available through the CARE Program. Staff must be on the premises of each facility from the hours of 8pm to 8am daily. Services provided by Residential Housing are limited to room and board.

III. BILLING INFORMATION

A. Documentation

Documentation of persons residing within the facility must be maintained to verify services for which reimbursement is claimed.

B. Unit of Service

A unit of service will be one (1) day.

C. Cost Centers

Examples of allowable costs are rent, utilities, building depreciation, maintenance, insurance, capital assets depreciation, supplies and travel. Providers shall participate in the planning, development, and implementation of coordinated transportation efforts. Failure to participate may result in disallowance of travel costs.

D. Deadline for Billing Submission

Billing for services provided during this contract period must be submitted by June 9, 2005. Services billed after this date will not be paid.

Behavior Management Systems, Rapid City

Written by Sandy Diegel, Executive Director

Population Challenges
We serve a wide range of individuals from the urban upper class to the poverty stricken Pine Ridge Indian Reservation and from young children to the elderly. We have four full time offices (two in Rapid City, one in Spearfish and one in Hot Springs) providing our communities with staff possessing a variety of skills and experience. Evening office hours are available in all locations. We continue to see a large population of adults with severe and persistent mental illness and substance abuse problems (dual diagnosis). There is not funding specific to address the needs of this population.

Services and Philosophy
Programs to be highlighted are:

- Family Pathways is our outreach program designed specifically for children/ adolescents and their families who need intensive services and coordination of services provided by a variety of professionals. Extensive services are provided in most public schools in our service area, foster homes, the STAR Academy, QUEST and EXCEL programs in Custer, and to STAR Academy graduates. This program provides in-home individual and/or family therapy, education, and support; out of home therapy in the child's school or other community location; group therapy; play therapy; parent/child interactive training; case management including coordination with other service providers; psychiatric assessments and medication if necessary; and 24 hour emergency services.
- Professional Services provides outpatient counseling and related services to the general public, as well as specific assistance for the business community. This program provides individual, group and family counseling for children, adolescents, adults, and couples; educational workshops; children, family, and adult support services; employee assistance programs; management and staff training; psychological testing; compulsive gambling treatment; and 24 hour emergency services.
- Mainstream Mental Health Services and IMPACT-West assists adults with major mental illness. These programs provide evaluation and referral; case management; medication management; drop-in programs; housing; vocational support and training; education and therapy groups; protection payee services; and 24 hour emergency services. Two residential living centers – a 24-bed and an 8-bed facility – are part of the program as is an on site 17-unit apartment building. Comprehensive vocational services are provided through a contract with the South Dakota Department of Vocational Rehabilitation. Extensive homeless outreach services are provided through coordination of services with approximately 35 agencies representing the Rapid City Homeless Coalition.
- Full Circle is a residential treatment program for pregnant substance-abusing women and substance-abusing women with young children. This program is designed to prevent birth defects due to a mother's drug or alcohol abuse while pregnant and help

mother's become better parents and role models to their children. This program's services include alcohol and drug abuse treatment, prenatal care, parent education, and case management. The majority of clients have co-occurring substance abuse and mental health issues.

Employment Services
Behavior Management Systems provides pre-vocational sites for skill building and assessments in our Rapid City and Spearfish offices. We provide pre-vocational classes to prepare for vocational work. Behavior Management Systems also provides support through Mainstream's CARE Teams by assisting clients in finding an appropriate vocational environment, and then support those clients in maintaining community employment. Our vocational program won a National Award in 2000 as a program of excellence from the President's Committee on Employing People with Disabilities.

Best Practices
We have a collaborative arrangement with Rapid City Community Health whereby we have master's level counseling interns onsite to provide low fee or no fee counseling to North Rapid City, a medically under-served area of the community. We also have an agreement in the Martin Community Health Center whereby we have a part time counselor practicing out of this clinic.

In March 1995, we made a commitment to quality and developed a comprehensive Continuous Quality Improvement (CQI) Plan. The commitment to CQI is evident in our philosophy, chosen values and principles. Implementation of CQI has increased our referral base as well as increased productivity and reduced costs. The CQI Plan includes a comprehensive quality assurance program which includes customer and referral satisfaction surveys, clinical records review, case consultations and a comprehensive management information system to integrate clinical records, billing and other management information.

In addition to the state required training in CPR, medication and other areas, staff receive training specific to their discipline and extensive training in other quality improvement and client satisfaction issues.

We own an apartment building to provide affordable housing options to clients in Rapid City. We purchased this property because of the huge waiting list for affordable housing in Rapid City and the lack of priority landlords give our clients.

We have a collaborative agreement with Rural America Initiatives Early Headstart program whereby we provide a counselor, onsite, to provide behavioral observation and treatment recommendations to parents. We provide behavioral health training to staff and parents and in some cases, direct counseling to the families.

We have developed extensive services for the corrections system ranging from basic outpatient groups to intensive residential services to onsite services at local correctional facilities. The Federal Prison system asked us to pilot a national pre-release program

whereby inmates with mental illnesses come to our program up to six months prior to their release date. We then get them stabilized on medication and provide needed services and referrals to assist them to be successful in their home communities. We collaborate with Pennington County Work Release on this program. Often times Federal Probation will continue this service or do a step down to an intensive residential/case management model upon release. We also provide onsite crisis intervention, group & individual services and jailer consultation at the Pennington County Jail and Juvenile Services Center and State operated correctional facilities in our area.

Our Full Circle residential treatment program for pregnant and parenting females with substance abuse problems was the first of it's kind in the State of South Dakota. All babies born in the program have not had any visible sign of fetal alcohol syndrome. In addition to learning how to stay sober or clean, these women are learning how to parent their children to prevent future out of home placement.

Unique Challenges

One of the challenges we face is the size of our catchment area. We serve over 7,000 individuals covering a 20,000 square mile area in South Dakota's ten western counties. We have are challenged by high competition in the urban areas such as Rapid City and Spearfish. We also face a challenge in recruiting and retaining adequate staff to provide services in remote areas.

The Rapid City Human Resource Association recently conducted a comprehensive salary survey whereby we found that we are paying approximately 20% below market value for most of our salaries. Our board has made a commitment to make these salary adjustments if we obtain adequate funding to support those increases. In absence of these adjustments, our staff turnover will likely escalate, jeopardizing our commitment to providing quality services to our clients.

The Future

We plan to work on eliminating our waiting list for children's services with additional funding received and through the use of an intake specialist who will provide immediate crisis and support services to families when they are referred and then triage them to available Family Pathways staff when they have an opening. We are also participating in the statewide system of care intensive case management model for children's services.

We would like to develop closer ties with the primary care community for more integration of behavioral and physical health.

And finally, we need to begin planning for the needs of the elderly, which will become a major need over the next 5 years. This may include working with nursing homes, assisted living centers and home health agencies, and working towards a funding base for this population.

Capital Area Counseling, Pierre, SD

Written by Dennis Pfrimmer, Executive Director

Population Challenges
Capital Area Counseling Service provides services to people of every age, race, gender, and economic level. The primary challenge for this agency is to adequately provide the needed services to these age groups as well as the other age groups with inadequate financial and human resources. We are constantly addressing the ways to best utilize existing resources and develop others in order to meet the service needs of our eight-county service area.

Philosophy
Capital Area Counseling Service is dedicated to serving people whose lives have been disrupted by chemical dependency or mental health problems with compassion and respect for each person's dignity.

Services
We provide the following services:

- Alcohol and Drug Services are a community resource to facilitate change by providing a pathway of prevention and a doorway to recovery from chemical dependency or substance abuse.
- Eye Opener classes are available to youth convicted of alcohol violations.
- Men and Women aftercare classes are available for people needing help with alcohol and drug abuse after they have completed intensive therapy.
- Children's Mental Health Services are dedicated to providing high quality, affordable counseling services to children and their families to promote healthier, better-adjusted and happier children.
- Care Center helps support severely and persistently mentally ill adults while promoting consumer independence through the help of medication management and health promotion using a qualified staff of nurses and Case Managers.
- Medical Services Unit serves consumers of all ages by monitoring medications in conjunction with therapy to help consumers maintain a high quality of life.
- Juvenile Offenders Program helps young adults make the right decisions with moral and legal issues. This program promotes healthy decisions through interactive group therapy with clinicians as well as one-on-one time. This program is relatively new to Capital Area Counseling and shows promising results by serving at-risk adolescents.
- Dual Diagnosis Program helps consumers with co-occurring alcohol/drug and mental health needs.
- Therapeutic Foster Care uses a therapeutic model to help foster children adjust to new or changing environments. This program helps find parents for foster children and has programs available for those that wish to care for foster children on a temporary basis.
- Prevention and Outreach programs go into schools and other organizations to teach the dangers of alcohol and other drugs in vulnerable age groups such as children and

teens. Prevention works with other groups on events such as the Pierre and Ft. Pierre after-prom parties that encourage teens to do things other than use alcohol and drugs. These events have proven very successful.

- Intake is the first unit to see clients. In the past year, the intake process has been streamlined to ensure that the consumers' easy access to care is paramount.
- The Development Unit ensures that there is proper funding for expanding programs at CACS now and in the future through grant writing and fund raising.

Best Practices

Capital Area Counseling is currently assisting St. Mary's Healthcare Center with the Crisis Room. We have three Qualified Mental Health Professionals employed at Capital Area Counseling to assist people with mental health emergencies. This is a positive improvement from the past when those with crisis needs were taken to the Hughes County Jail. The Crisis Room has seen a large number of people since its inception in 1998.

In addition to the Crisis Room, CACS is working with other area agencies to provide the Parenting Center, a Visitation and Exchange center. Under the guidance of an advisory board, CACS has launched this program and has begun staffing the center on weekends for non-custodial parents to visit their child(ren). This is the first visitation and exchange center in the area. We will also be incorporating a therapeutic model once things get rolling.

The Future

Our future goals include continuing the level of care to our target populations as well as further defining our alcohol/drug and mental health services. One of the ways we plan to better provide these services is to locate our services at St. Mary's Healthcare Center. This move will take place by September 1st, 2001. We believe this will give the agency greater visibility with the health care community and the community as a whole while increasing consumers' confidentiality.

Capital Area Counseling has also begun the process of working with the Hughes County Sheriff's Office to provide supervision staff for the Juvenile Detention Center. JDC will be staffed and in operation by the end of the year.

Community Counseling Services, Huron, SD

Written by Duane R. Majeres, MS., Executive Director

Population Challenges
The main office for our agency is located in Huron, South Dakota with a full-time, fully staffed office in Madison. Our service area is comprised of six counties across east central South Dakota with a population base of 42,000 residents. The largest city has a population of 12,000 and the economy of the region is primarily agriculture. The population is homogenous with the exception of the state's smallest reservation being located in our far eastern county. The area has a significant aging population, as young people tend to migrate out of the region. Our service area has the distinction of being located in the area of the State which has the highest rate of population decrease as people move out of agriculture and toward larger population centers that offer more job opportunities. The challenge for our agency is to provide a stable base of behavioral health services as the population shifts and the economic base of the region deteriorates.

Philosophy and Services
The philosophy of our agency is to maximize accessibility to services and to network with other human service providers in the area to amplify the limited resources of the agency. The agency has mental health and chemical dependency services available in all six counties of the service area at least weekly and more often as demand dictates. CCS has a long history of integrating mental health and chemical dependency treatment and in having a full continuum of services for treating the most severe mentally ill adults in a community setting.

Unique within the community mental health system of South Dakota we employ school psychologists to conduct psycho-educational assessments and early intervention services for area school districts. By doing so we are able to integrate the educational and behavioral health resources of the area. Other staff provide a full range of mental health and chemical dependency treatment services. We have outpatient counseling, home-based services, CARE services, transitional residence, psychological consultation and testing, community prevention activities, after hours crisis on-call services, psychiatric services, hospital crisis bed, and a full continuum of outpatient chemical dependency services.

Best Practices
Services to adults with a severe and persistent mental illness receive priority funding and support from this agency. We employ a full-time psychiatrist dedicated to service patients of the agency throughout the service area. In addition to medication management, therapy and case management, a significant emphasis is placed on making affordable, supported housing available in the community to all individuals with a psychiatric disability. Resources are quickly mobilized for individuals experiencing a psychiatric relapse. We have a variety of community resources to offer people as an alternative to hospitalization when they are experiencing a relapse in their psychiatric

symptoms to include intense in-home supports, short-term residential care with 24-hour supervision, or admission to a local hospital with specialized crisis room care.

The close working relationship between our mental health and chemical dependency units assures an integrated approach to behavioral health treatment. Also, our presence in rural health clinics and our frequent communication with area physicians and ministers encourages and supports a holistic approach to treatment.

In our Madison office we have a psychiatric resident rotation for the USD Medical School's Department of Psychiatry and a pre-doctoral field placement for the USD Clinical Psychology Department. These training opportunities are mutually beneficial for students and staff as it gives students direct opportunities to learn and keeps the skill level of the staff current.

Our services to the aged population includes counseling, medication management in eight nursing homes, support to home health care staff, and working with senior centers to develop behavioral health supports for elderly living in the community. Each community in the service area has at least one program unique to their community to support elderly individuals living independently in the community.

Unique Problems

The out-migration of the population in the service area and the strong dependence on agriculture to support the economy of the area are our most pressing long-term concerns. Planned upgrades to the highway and rail systems running through the area will hopefully stem the tide of out-migration of young people and encourage the diversification of industry in the region. With the anticipated new industry coming into the region there is expected to be an increase in numbers and diversity of jobs available for psychiatrically impaired workers eager to rejoin the labor market.

Another challenge unique to this region is the shortage of ancillary behavioral health services in the immediate area, especially in the area of children's services. The agency staff is constantly challenged to develop supports for children and families in crisis to avoid out of region placements. There are no therapeutic foster homes, respite care facilities or short-term treatment care facilities for children in the area. However, Beadle County (Huron) is in the process of opening a small detention center for adolescents who have come to the attention of the juvenile justice system.

The Future

Short-term goals of the agency that are achievable and in progress include broadening the continuum of care for SED children through working with local school districts and applying for foundation grants to service children within their home community; adding to our inventory of supportive housing for psychiatrically disabled adults by working with local housing authorities to access PATH and HUD resources; implementing a comprehensive management information system (ECHO) that supports clinical efficiency and administrative effectiveness; adding the resource of a second full-time psychiatrist to manage the medications of SPMI adults and nursing home consults; continue our efforts

at behavioral and physical health care integration by working with local hospitals and clinics; and implementing an IMPACT Team in Huron to better serve the most needy consumers currently in the community as well as being able to accept new referrals of SPMI consumers from the State psychiatric hospital. By continuing to hire the best-trained professional staff we can allow them the freedom to practice their profession with minimal constraints, and we will be able to, creatively and effectively, meet the behavioral health demands of the area in spite of shortages in public funding.

Dakota Counseling Institute, Mitchell, SD

Written by Michelle Carpenter, Executive Director

Population Challenges

Dakota Counseling Institute was founded in 1970. We serve residents of Davison, Hanson, Sanborn, Aurora, and Brule counties. The population of our service area is about 34,000, with most residents living in rural areas. Our main office is located in Mitchell, South Dakota. We operate a satellite office in Chamberlain three days per week. Most of the counties in our service area have modest financial resources and are unable to provide sufficient funding to support more outreach activities. The economy of our service area is heavily dependent upon agriculture and many residents find that their family financial resources can vary considerably from year to year. It is often difficult to find resources to support the provision of services to persons who do not meet the criteria for adults with severe and persistent mental illness or children with serious emotional disturbance. Many of these people do not qualify to have their services reimbursed by state contract funds or Medicaid and do not have sufficient resources to pay for the services themselves.

Services and Philosophy

Dakota Counseling Institute offers a full range of non-residential mental health services to persons of all age groups. We work in concert with the Community Alcohol and Drug Center in Mitchell to assure that persons also needing treatment for chemical dependency have those services available to them. When possible services to SPMI adults and SED children are provided in their homes, apartments, or schools. Treatment services are coordinated with other service providers and agencies in the community to eliminate duplication of services and to insure that persons receive a comprehensive approach designed to optimize the probability of a successful long-term outcome.

Best Practices

We regard our services to SPMI adults as among the best in South Dakota. We have used the current CARE Team model since the inception of our SPMI program in the late 1970's. Dakota Counseling Institute and Community Counseling Services in Huron received a three-year federal grant to develop community support programs, as they were called at that time. Our program was developed with the assistance of Dr. Leonard Stein of the PACT program in Wisconsin. He met with staff in both Mitchell and Huron and helped us structure our staff, activities, and procedures. We also sent staff to spend time at Fountain House and borrowed concepts from the clubhouse model in developing our program.

Services to SED children are another strength of Dakota Counseling Institute. We have recently increased the capacity of our in-home services to SED children and their families. We provide services to a number of adolescent group homes and correctional facilities in the area. Services are provided at the Abbott House, Springfield Academy, Chamberlain Academy, Our Home, and Cornell Companies. We also provide specialized

services to students in the Mitchell and Chamberlain Public School systems. General outpatient services are provided for a wide range of problems faced by children and adolescents.

Since 1979, we have served as a training site for clinical psychology graduate students from the University of South Dakota. This relationship with the University has been mutually beneficial. In 2004 we will have two psychology interns and two psychiatric residents.

Employment Services
Dakota Counseling Institute developed Career Connections in conjunction with the Mitchell Area Adjustment Training Center. The first four years of the project were supported, in part, by an establishment grant from the South Dakota Division of Rehabilitation Services. Career Connections provides a wide variety of employment services for both persons with disabilities and those without disabilities. A broad range of services is also provided to employers. It became apparent toward the end of fiscal year 1999 that Career Connections would not be fiscally sustainable structured as it was and operated jointly by the two agencies. It was also apparent that it might be sustainable if folded into the Mitchell Area Adjustment Training Center's existing vocational program. By mutual agreement, this was accomplished on July 1, 1999. Career Connections continues to provide the bulk of employment services for Dakota Counseling Institute. Consumers are referred to Career Connections either directly or through the local counselor for the Division of Rehabilitation Services. Career Connections provides all services related to finding employment, situational evaluations, vocational testing, job coaching and short-term follow-up efforts to maintain employment and do almost all of the long-term follow-up support. CARE Team staff work closely with both the employee and employer in an attempt to maintain employment. CARE Team members often transport consumers to their jobs, if other transportation is unavailable. There is a close working relationship between CARE Team staff, Career Connections staff, and the counselor for the Division of Rehabilitation Services.

Unique Challenges
As mentioned above, it is often difficult to find sources of support for services provided to lower income people who do not qualify for Medicaid or state contract funding, and who have no insurance. Support form the two more populous counties in our service area is low in one case and nonexistent in the other. Our remaining three counties provide enough support to meet the mental health needs of their citizens who do not have another payment source. The provision of psychiatry services has been another longstanding challenge at Dakota Counseling Institute. The cost of providing these essential services has consistently greatly exceeded the reimbursement for them.

The Future
In the future, we intend to expand outreach activities in our CARE and children's services programs. Although many clinical record keeping aspects of our operation have been computerized since 1991, we intend to continue development in this area. This will allow us to keep our support staff small, thereby maximizing the resources available for

assessment and treatment. We look forward to forming partnerships with other health care providers through the South Dakota Council of Mental Health Centers to improve the quality and scope of services available to residents of our service area. We have begun the cross training of staff to develop a co-occurring tract to better serve individuals with substance abuse and mental health issues.

East Central Mental Health Center, Brookings, SD

Written by William Price Ph.D., Executive Director

Population Challenges
We are a non-profit community mental health center serving the needs of Brookings, SD (city and county), a rural agricultural and university community, with a population of approximately 25,000. The Center takes pride in 35 years of providing valued, local care. In a given year the center will serve 1,200 to 1,400 children and adults with mental illness, chemical dependency, or gambling addictions, including also individuals covered by employer-based EAP programs who seek help with a range of personal problems. Interdisciplinary and intensive services are available for persons who are severely and persistently mentally ill, and children who are severely emotionally disturbed. We seek to provide counseling, treatment, case management, in-home services, and support services to assist individuals and families in achieving optimal mental health and experiencing a more fulfilling and independent life in the community. Special populations include dual diagnosis (persons with co-occurring disorders of mental illness and chemical addictions), mentally ill persons at risk of homelessness, and a small portion of the active caseload is Native American. Our catchment area is rural, but in the city there is a large contingent of temporary residents—persons living in Brookings for the purpose of attending South Dakota State University. Although there are counseling services on campus, there is a steady enrollment at ECMH/CD of young adults seeking counseling, medication management or chemical dependency services.

Philosophy and Services
Services provided are listed in enclosed brochure. Staff provide outpatient assessment and counseling, assertive community treatment, home-based child and family services, consultation with area service providers, psychosocial programming, medication management, and addictions prevention, treatment, aftercare and intensive outpatient services, and 24 hour emergency response. Our general philosophy of services is one of partnership with the person served and a focus on client-centered treatment planning. There is an emphasis on recovery and restoring wellness, assisting the individual or family in a return to higher levels of functioning.

Employment Services
The Center offers community supported employment through the CARE team and interdisciplinary treatment planning with Vocational Rehabilitation Services. CARE staff members visit employers and may be involved in initial job development and in post-employment monitoring to help assure the success of employed clients. Job placement and development activities are negotiated for direct service support on a case-by-case basis. One of the CARE staff members is a liaison worker between mental health/CD Programs and the various vocational programs and services offered in the community. Regular attendance at vocational staff meetings often leads to increased opportunities for our clients. Case management and job related problem solving, job coaching, and job follow along are offered to those individuals already employed in the community to assist in maintaining that employment.

All clients desiring work or with identified work potential are assisted in registering with Job Service. Referrals and on-going work relationships at the agency level also include the Department of Vocational Rehabilitation Services and the Career Learning Center.

Best Practices
The assertive community treatment approach, involving interdisciplinary interventions for the chronically mentally ill adult, a developmental approach to child and family issues including interventions in the home, and a full array of outpatient treatment options for substance abusers, are three areas of pride for our professional staff. In the area of children's services, staff network and collaborate with other human service providers through Project EAST (Educationally based) a community-wide Child Protection Team, and a local Coalition for Youth and Community (response to increasing violence and seeking to promote safe and healthy communities). With the large population of college students there has been a growth in treatment offerings for underage drinkers. In response to requests from Court Services, the children's team has conducted an 8-week "Responsible Thinking" group for adolescents on probation. The CARE Team staff and Chemical Dependency staff work together offering dual disorders outpatient treatment and aftercare. General adult outpatient services also include offerings of "Anger Management" and Bi-Polar treatment groups.

Unique Problems
We are a small center (3rd smallest of 11 in SD) which strives to maintain an array of services to support community living for persons with severe and persistent mental illness. In a quasi-rural area of the state, the people we serve experience a shortage of affordable housing and stiff competition for employment opportunities (given the university student population of approximately 8,000). The absence of a local crisis residential bed opportunity means that persons requiring inpatient care (beyond a 23-hour medical hold) must be transported out of the area for this psychiatric care. We have been successful in retaining part-time psychiatric coverage to deliver medication management services to our clients 8 days per month.

The Future
Our Center seeks to strengthen our system of local care for persons experiencing mental health or addictions problems. We will maintain and improve service delivery and successful client outcomes for the SPMI and SED client populations through a system of internal care management and quality improvement. The implementation of a fully integrated computer software system (ECHO Management Systems) is underway and will be a vehicle for closer clinical and administrative attention to critical elements of care. With the tools at clinician's fingertips and information available in "real-time" we plan to effectively and efficiently manage service delivery to optimize desired client outcomes and maximize treatment resources available to the people of Brookings County.

The Human Service Agency, Watertown, SD

Written by Charles Sherman, Ph.D., Executive Director

Population Challenges
Our agency is located in Watertown, South Dakota. Watertown is primarily an agricultural environment in northeastern South Dakota. We have a rural economy, and as such we provide outreach services to a population of approximately 60,000 people over seven counties. This population is likely to be representative of the rest of South Dakota, with the exception of a lack of minority population. The only significant amount of minority members that we serve would be the Hispanic population. We provide psychological consultation and psychiatric consultation to a large number of elderly persons both in our outpatient mental health clinic in Watertown and through consultations provided in nursing homes throughout the area. We are extensively involved in providing services to young people due to our extensive involvement in drug and alcohol dependency program. The children's service also provides home-based counseling and outpatient counseling for children.

Approximately 80% of our clientele have a yearly income less than $30,000 and a significant portion of those are earning less than $20,000. We are very much involved in working with the persistent mentally ill who are either homeless or at risk for homelessness. Our drop-in center provides a unique service for these individuals.

Services and Philosophy
HSA provides a full range of mental health services with the exception of an inpatient service. We have outpatient, home-based, CARE services, transitional residence, psychological consultation and testing, psychiatric services four days per week, hospital consultation, drop-in center/clubhouse service, dual-diagnosis for mental health and chemical dependency disabilities, and consultation to the adjustment training center for behavior intervention for individuals with developmental disabilities.

Unique within the State of South Dakota is the incorporation of mental health, chemical dependency, and developmental disability services within one organization and found all within one building. We believe this provides greater cross-fertilization of ideas and improves the ease of consultation for the developmental disability service. We also believe that we can reduce administrative overhead costs by not replicating services and equipment.

Employment Services
The staff of Employment Connections assists individuals in locating and securing employment. The CARE Program has a vocational specialist and a job trainer that assist severely and persistently mentally ill individuals in working with the Department of Vocational Services and in locating, securing and maintaining employment. The CARE Program staff also work with severely and persistently mentally ill individuals to provide, develop, and maintain employment supports.

Best Practices
In 1998 we started a residential program, Serenity Hills, for dual diagnosis clients, mental health and chemical dependency. This program is the first of its kind in the state to be specifically designed to provide psychiatric and psychological services for addressing the mental health issues for individuals with chemically dependency. Also provided at Serenity Hills is a detoxification unit.

Unique Problems
In addition to the challenge of working with people with very difficult problems is the fact that there are relatively few individuals who receive services through us who have adequate health insurance coverage for mental health care. The lack of mental health coverage in most insurance plans through employers in this area is particularly troublesome.

Also of note would be the difficulty we have had over the last year with high health insurance costs and the lack of financial increases in funding through the state. We will be hard pressed to continue to provide quality services with well-trained and highly qualified professionals when the rate of increases for reimbursement is not keeping up with inflation.

The Future
Despite the financial challenges set before us, our staff is committed to providing the highest quality service possible. New program development like the dual-diagnosis program will continue. We hope to focus on early intervention at the elementary school level for conflict resolution and anger management in order to diminish teen violence. We see the need for active marketing to increase the private funding as our current situation leaves us much too dependent on government funding. At some point in the future, we believe that further consolidation of community resources may be necessary and would hope that if this proved inevitable, it could be done in a collaborative manner that results in a shared partnership with other agencies.

Lewis & Clark Behavioral Health Services, Yankton, SD

Written by Tom Stanage, Executive Director

Population Challenges
Populations served by Lewis & Clark Behavioral Health Services (L&CBHS) include individuals in the following seven counties of southeastern South Dakota: Bon Homme, Charles Mix, Clay, Douglas, Hutchinson, Union and Yankton. We serve a catchment area of approximately 76,000 South Dakota residents (2000 Census).

We serve a diverse population. Special population considerations include Native Americans, elderly, Hispanic, individuals who have serious mental illnesses, children and their families, and rural/farm families. The Human Services Center (HSC) (South Dakota's state operated psychiatric and chemical dependency inpatient facility) is located in Yankton. Due to this facility's location we serve a large number of individuals with severe psychiatric illnesses.

The catchment area for our agency contains the highest concentration of elderly citizens in the state and thus a large number of nursing homes. We provide geriatric mental health services throughout the area, providing services in almost all of the area nursing homes. Often, nursing homes in this area are the choice of discharge for geriatric patients from HSC due to the expertise offered by our staff.

The University of South Dakota and Mount Mary College are located in the catchment area. Students who attend these institutions come from all across South Dakota and from other states presenting unique challenges when mental health services are needed.

Yankton Sioux Tribe is located in the service area. L&CBHS provide outpatient mental health services to Native American children and their families through home-based services. The agency works closely with Yankton Sioux Tribe and Indian Health Services. L&CBHS offers culturally appropriate services for Native American consumers.

Services and Philosophy
Our mission is to serve individuals so that they may achieve a more independent and satisfying life. The primary consumers of L&CBHS are residents of the catchment area who have serious mental illnesses, children with severe emotional disturbances and their families, chemical dependency or are concerned with optimal mental health. Our intent is to work in cooperation with individuals and families being served, advocacy groups, governmental entities, United Way, other agencies and concerned citizens.

The guiding principles for L&CBHS:
- Services shall be consumer driven, individualized and tailored to meet the needs of each consumer and his/her family.
- Duties will be performed with professional integrity and honesty, always striving for excellence.

- Services will be provided in the most efficient and effective manner possible to maximize available resources.
- The environment will be one that values consumers, their families, and personnel at the agency to encourage teamwork, growth and improvement through development and empowerment.

L&CBHS offers a wide variety of mental health services and alcohol and drug treatment services. Included are services are available for children with severe emotional disturbances and their families, delivered throughout the service area, including at the family's home. Children/family services range from brief, solution focused family mediation services and parent education to intensive home based therapy services. A service coordination program is available to help children with special needs.

We offer a wide range of services for adults. These services include medication management, day treatment, counseling, case management, and vocational/employment. Psychiatric services are available in the Yankton office. L&CBHS offers outreach geriatric services throughout the catchment area.

Employment Services
Services offered by Lewis & Clark Behavioral Health Services, Inc. in regards to securing employment opportunities and/or maintaining employment for SPMI adults and/or SED children include:

- **Job Counseling** to identify and begin to work with clients on employment goals, skills, training needs, interview techniques, completing job applications, as well as job seeking skills.
- **Job Coaching** to practice and improve employment skills necessary to obtain employment and to promote job satisfaction and stability.
- **Job Placement** to contact employers, inform them about hiring individuals with disabilities, and identify employment possibilities for our consumers.
- **Follow Along** services to assure success on the job.
- **Referrals** are made to Job Service of South Dakota to register and explore job listings.

Supportive services offered to those individuals already employed within the community might include liaison services by the supportive employment specialist to maintain ongoing support. The job coach may go on site to monitor and assist the employee and to visit with the employer to assure job completion and resolve any problems.

L&CBHS Supportive Employment Program provides employment support designed to maximize each individual's vocational potential. Services are provided to individuals who are involved with the SD Division of Rehabilitation Services.

Best Practices
Services are routinely provided outside of "normal" business hours, especially child/family services and emergency services. Every effort is made to consider issues

regarding the availability and accessibility of services when scheduling with clients on weekend hours in order to maximize accessibility. We make every effort to do so within the limits of currently available resources.

L&CBHS is committed to providing high quality services. We are continually striving to improve and develop services that meet the needs of each individual served. The agency offers a wide variety of services in a very diverse population, and provides a continuum of professional services including psychiatric services from board certified psychiatrists. In addition, we provide psychological services, social work, nursing, counseling, and case management.

Our long-standing programs include day treatment services for individuals who have severe and persistent mental illnesses, geriatric outreach and specialized children's services. These services were all developed to meet a particular identified need within the area.

Unique Problems

Our catchment area is basically rural. Providing services throughout the large catchment area is problematic. We hire professional staff who live in various parts of the service area to better serve the rural areas.

A unique challenge to L&CBHS is the Hispanic population who work in the meat packing plants, agriculture and other business in the area. The Hispanic population is growing in the area due to available work. With this population growth, L&CBHS will be challenged to offer culturally relevant services for this population. Specific challenges include the provision of services throughout a large and diverse catchment area. Another challenge includes meeting requests for services from a population from another state.

The biggest challenge is to meet needs within available funding streams. We have traditionally been one of the centers who received the smallest per capita support from state government, especially considering the large number of individuals who are served and meet the state's target population.

Housing needs are growing, especially for adults who are seriously and persistently mentally ill. There is a lack of supervised housing making it difficult to provide a quality living environment for adults with SPMI.

Future Direction

We will continue to offer those services that meet the needs of our consumers. Our goal is to assist all those in need of mental health services and to offer services, which improve the quality of life for citizens of the area. L&CBHS will continue to analyze its services and make improvements and additions within available resources.

Northeastern Mental Health Center, Aberdeen, SD

Written by Michael E. Forgy, Executive Director

The Challenge for Mental Health

The *President's New Freedom Commission Report* (2003) is the most recent in a series of findings that the mental health system in the United States is "broken." It fails to serve the people needing service and fails to focus where people need focus.

An issue raised by this report is the organizational underpinnings of the mental health system. Rather than delineate an appropriate organizational philosophy, the *President's New Freedom Commission Report* alludes to an earlier report from the Institute of Medicine: *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001). This report explicitly cites the science of complex dynamic systems as an effective "evidence-based" foundation for clinical service provision and administrative organization.

Management and staff at Northeastern Mental Health Center (NEMHC) take these reports, together with the *South Dakota Children's Mental Health Task Force – Final Report* (2003), as systemic requirements for change. If the mental health system is "broken," and we know how to "fix" it, what does that mean for actual service provision?

The *President's New Freedom Commission Report* delineates two "core principles," presaged or echoed by many other reports, for *transforming the mental health service delivery system*:

1. Services and treatments must be ***consumer and family centered***, geared to give consumers ***real and meaningful choices about treatment options and providers*** – not oriented to the requirements of bureaucracies
2. Care must focus on ***increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience***, not just on managing symptoms

Services and Epistemology

In order to meet the challenge of completely revamping the system of behavioral health, an underlying issue must be handled. That is, what is the basis upon which the services and programs offered by behavioral health providers is founded and supported? [What is the "thinking" that underlies the thinking that leads to service provision? – This is epistemology. – How do we know what we think we know?]

At NEMHC epistemology is in the process of transformation. The transformation is from a "bedrock" belief in "mental illness," leading to culturally incompetent attempts to assure conformity, compliance and community comfort, to a belief in consumer competence and provision of services in a manner that meets needs – recognizing strengths and capabilities. It is also a transformation from providing "programs," then fitting consumers into the available program(s), to creating meaningful alternatives and choices and designing services around and for each and every individual and/or family.

This goes beyond "philosophy." It requires changing basic belief concepts regarding:

× who needs services × who receives services × who provides services	× how services are provided × how all of these factors interact to form an effective "service system" for each individual, couple and family involved

This is an epistemology of interaction and relationship, based in the principles of the science of complex dynamic systems. Practices flow naturally and appropriately from this base.

NEMHC is organized around five divisions, each of which provides emergency services:

1. Family Based Services (FBS) – The division that provides services throughout the 10-county, ≈ 11,000 sq. mi. service area. The vast majority of FBS service is provision of education, support and/or therapy with family members in their own homes. FBS staff also coordinate services, provide consultation with schools and other community resources, facilitate child/family team meetings, develop community resources for families, etc. FBS includes a Therapeutic Foster Care program.
2. Outpatient Services (OP) – There are OP offices in Aberdeen, Webster, Redfield and Mobridge. This is a primarily office-based service, often focused on provision of psychotherapy and/or support to specific individuals.
3. CARE Services – The CARE staff serves people who carry the designation "severely and persistently mentally ill." This service is offered primarily in Aberdeen, with OP and/or FBS staff responsible for working with people who live in other parts of the service region. The major focus – leading to a profound transformation for CARE – is definition of how services can and should be provided in order to promote recovery; moving away from basic "maintenance" service provision.
4. Medical Services – NEMHC employs a full-time psychiatrist and psychiatric nurse-practitioner. These professionals, along with registered nurses, staff a full service psychiatric office. The NEMHC psychiatrist also serves as medical director for the psychiatric inpatient unit at Avera St. Luke's Hospital.
5. Residential Services (for children/adolescents) – Dakota House is the only children/adolescent residential facility in South Dakota operated by a mental health center. Licensed for eighteen children and/or adolescents, the program combines group living, therapy, psychiatric care, behavioral programs, life skills learning and family involvement. The program includes an approved special education school that allows studies to proceed while people are in residential treatment – as well as serving as a resource for Aberdeen school students.

These divisions have the potential to provide a comprehensive range of effective, consumer and family centered array of services. As alluded to above, this is the challenge for NEMHC.

Employment Services
Northeastern Mental Health Center's CARE Program offers prevocational groups focusing on skill development and provision of general vocational information. An exciting new collaboration is a contract between NEMHC and the Division of Vocational Rehabilitation. NEMHC has a staff member in the CARE program dedicated to employment services. Utilizing this staff member, the CARE program offers job finding, vocational assistance and a full-range of vocational counseling options.

Best Practices
Rather than "best practices," NEMHC is dedicated to evidence-based practices and processes. The behavioral health field has grown and been sustained by people tearing down "walls" and working beyond the existing "walls" (e.g., PACT; Wraparound – both related to family based services). Evidence-based practices so far identified show how they can reduce symptoms and relapse, and help people work in dead end jobs, *but do not show how they help people to recover*. For the most part, outcomes like empowerment and meaningful work are missing. This bolsters the argument that the substantive component should be both evidence-based *practices* and evidence-based *processes*.

- Currently in evidence-based practices research the focus is on "manualized models" (i.e., program structures – e.g., caseload size, team composition, number of team meetings, etc.)
- Continuing to study program structure alone in order to differentiate archetypes and their unique impacts on people's outcomes may not be where the *real* action is.
- Effective behavioral health investigations should also focus on the *process* – not simply the program structure.
- Interventions that appear different based on program structure may actually be very similar in terms of the *process* that is occurring between the practitioner(s) and the person(s) being served.
- While program structures have been examined for conceptual and empirical differences, a more appropriate focus of study, independent of the name of the program, may be measures of process – For example:

✓ the nature of the interactive relationship between the practitioner and service recipient; ✓ the practitioner's use of advice and coaching; ✓ collaborative goal setting with people; ✓ skill teaching; ✓ developing a person-centered plan;	✓ providing environmental accommodations; ✓ the service recipients' opinion about the practitioner; ✓ etc.

- The study of evidence-based *process* allows program ingredients to be viewed as supporting particular processes around which evidence is built.
- It is time to emphasize the human interactive process, as it occurs within differing programs, as a fundamental target of scientific research. Research literature on how people change and grow is what is relevant. The behavioral science literature, supported at times by mental health services research has identified certain human interactive processes that help people change and grow. These processes include:

✓ People experiencing a positive relationship with the people providing help; ✓ People setting their own goals; ✓ People being taught new skills;	✓ People encouraged to have positive expectancies and hope for change; ✓ People developing self awareness about aspects of their own behavior

A primary focus for NEMHC is integration of the (evidence-based) principles of ecosystemic family therapy throughout the organization's structure. This is a long-term goal and plan.

Unique Challenges

One challenge is geography – obviously providing effective behavioral health services throughout a region of ≈ 11,000 sq. mi. is a daunting task. The funding structure for such service provision continues to be an area of innovation by the Division of Mental Health.

The most unique challenge is moving the behavioral health system from a primary focus on program structures and documentation to total customer service. That constitutes the purpose and goal for NEMHC for the foreseeable future.

Southeastern Behavioral HealthCare, Sioux Falls, SD

Written by Vicki Rowe, Executive Director

Population Challenges
Southeastern Behavioral HealthCare (SBH) has been in existence since 1952 and currently serves residents of Minnehaha, Lincoln, McCook, and Turner Counties. Total population served is 187,093 with Minnehaha County being the largest population center in SD with a population of 148,287. Approximately 30% of the population are under 18 years of age. The service area has a small but growing population of minorities. Ninety percent of the residents in Minnehaha County are Caucasian, 1.5% African American, 1.9% American Indian, 1% Asian, and 2.1% Hispanic or Latino. Although the numbers are small, there are significant issues to deal with, as many are refugees from war torn areas of the world and some needing a wide range of services. There is a relatively large population of homeless in Sioux Falls. There is also a large population of female head of households. Nine percent of the population served has household incomes below the Federal poverty level; however 21% of the children live in households with incomes below the poverty level.

Services and Philosophy

Services to Adults with Severe and Persistent Mental Illness:
Community Support Services offers a full range of services for individuals suffering from a severe mental illness. Services are designed to enable people to function as independently in the community as possible and lead satisfying lives. We believe it is essential for people to have access to medications and ongoing supportive services including housing, work or constructive activity, basic skills training and case management.

Within our CARE (Continuous Assistance, Rehabilitation and Education) Program we provide case management to individuals, education about medications and mental illness to consumers and families, basic living skills training, psychiatric and nursing services, monitoring in the home or community, employment and homeless services and transitional housing. In addition we work with a significant number of consumers on accessing indigent medication programs and monitoring self-administration of medications. We operate a Clubhouse within Community Support Services that provides a structured, work-oriented schedule and activities through the use of crews. Consumers work alongside staff to run the Clubhouse and take part in decisions that impact the program. They operate their own snack shop and use the proceeds as they see fit to enhance the Clubhouse. The Clubhouse also offers a kitchen unit, where a meal is prepared and served Monday through Friday.

Employment Connection, through funding from the Department of Rehabilitation Services, assists individuals with mental illness in gaining and maintaining community employment. Employment Connection staff provide supports such as evaluations,

assessments, job coaching and long-term monitoring to ensure that each individual has the best chance for success in their chosen occupation.

Our Transitional Housing program offers residence to 12 individuals that need intensive services to re-integrate into the community or to prevent institutionalization when longer-term care is needed. Residents usually reside for 6-9 months allowing them time to stabilize the symptoms of their illness, secure financial benefits, vocational planning and training, schooling, establish a support system, and most importantly, develop skills that will allow them to live independently in the future.

The IMPACT Program, often referred to as a "hospital without walls", services consumers who have historically failed in community setting and who have had frequent hospitalizations. The IMPACT staff provide treatment rehabilitation and all support services to those who have a very serious mental illness and need intensive services. The program goal is to help people live successfully in the community and reduce the need for hospitalization.

Services for Children with Severe Emotional Disturbances:
Southeastern Behavioral HealthCare provides the traditional services outlined by the state: outpatient therapy, psychological testing when necessary, psychiatric services, home-based services, case management services, and family services with IFS families. SBH continues to rely on our Local Interagency Team for guidance on prioritization as well as providing multi-agency services to our children and families.

Southeastern has concentrated on providing early childhood prevention and intervention services. The number of younger children being referred to our agency with significant behavior and emotional problems has significantly increased over the past five years. SBH provides a number of outreach services to children including home and community based services and school based services. SBH offers individual and group counseling case management and parent education.

Southeastern collaborates with the Sioux Falls School District by offering mental health services at various sites throughout the District including the Bridges alternative program, the middle school alternative program, Washington and Roosevelt High Schools, and the Community Campus. We provide school based services through our outreach offices located in Lincoln, McCook and Turner Counties as well.

Southeastern also provides Anger Management treatment groups for boys and girls in different age ranges along with companion classes for parents of these children. Our agency continues to offer parenting education courses in Sioux Falls and Canton called Defiance to Compliance. SBH also offers ADHD parent education classes.

Best Practices
In addition to the innovative and collaborative programs mentioned above, Southeastern has entered into contracts with other community entities. We have a contract with the Minnehaha County Jail to provide on-site services for inmates to evaluate for high- risk

behaviors. This contract includes the provision of psychiatric services. We also have a contract with the local Community Health Center to provide on-site mental health services and to assist the Center with a depression project.
Southeastern has also established an internship program to deal with the mental health needs of adults and children who do not meet the funding criteria for target populations. Master's level interns, supervised by experienced staff deliver counseling services on a further reduced sliding fee basis.

SBH continues to encourage staff to continue their education. Many of our SED staff have or are receiving their Master's degrees on a part-time basis. Southeastern believes this has provided us with a highly educated and creative staff. Our agency also offers supervised internships for three major universities in the area. SBH continues to push staff being professionally licensed. Our agency now has a certified child play therapist on staff.

Southeastern continues to maintain a staff ready and able to respond to community disasters. Southeaster has trained staff in debriefing for Critical Incidence Stress Management. SBH is also working with the LOSS program in Sioux Falls to provide immediate counseling services to family members following the suicide of a loved one. The Sioux Falls Police Department works closely with this volunteer program.

In order to meet the demand for psychiatric services, Southeastern contracts with physicians from both Avera McKennan and Sioux Valley Hospital Systems. We utilize the USD Psychiatric Residency Program that provides two or three residents at a time to meet needs that can not be met by contract psychiatrists.

Unique Challenges
One of the major challenges for the agency is the increasing urbanization of Sioux Falls. Gangs, foreign populations, and a mobile population create a different working environment than our more rural areas. We are continuing to get more requests to serve children with language issues, cultural differences, or sexual orientation issues.

Surviving in the intensely competitive Sioux Falls market is challenging for SBH. There are numerous private providers. Because of the competition for third party resources, we often become the place of last resort, where people with no resources and with multi-problems are referred. Sioux Falls also has a large number of underemployed or working poor that have no access to insurance coverage.

SBH continues to have a large waiting list (currently over 80 individuals) for individuals with severe and persistent mental illness. The funding level for this population is not adequate to meet the growing demand for services. Southeastern in the only provider of community support services for this population in our service area.

Maintaining staff salary to retain good staff is a constant struggle. The no-show/reschedule rate for Medicaid clients is an alarming concern for us.

The Future

Our future goals are to:

- Continue to concentrate on early intervention services for children.
- Develop a "system of care" in concert with community providers and leaders to better meet the mental health needs of children.
- Increase capacity for service to reduce or eliminate waiting lists particularly in our Community Support Program.
- Provide competitive staff compensation in order to enable the agency to recruit and retain qualified staff.
- Develop an assisted living project for adults with severe and persistent mental illness who are homeless or at risk of homelessness and who need more intensive/assisted living services.

Southern Plains Behavioral Health Services, Winner, SD

Written by Dr. James Nardini, Executive Director

Population Challenges
We serve a four-county catchment area in south central South Dakota, including the Rosebud Indian Reservation. Because we live in a rural area where few services are available, our agency deals with the entire population of mental health/alcohol and drug services, including the elderly, youth, minorities, low-income, unemployed, etc. About fifty percent of our SED children are Native American. Because we are so isolated, we often have to develop services that are not available in larger areas. These unique problems cannot be referred to other agency services here because no services are available so we must often be innovative. Because we must reach so many people in a rural area, it is necessary for us to go to them often, rather than them come to us. We have developed a day program in so we might better serve the SPMI population. We go to the reservation on a regular basis several times a week because transportation is a problem, and we have offices in the schools so we can better meet the needs of the children during the school day. It is not unusual for us during the summer to go to the recreational areas, including baseball camps, baseball games, rodeos, wacipis, and other such places where our clients congregate. It is necessary for us to coordinate alcohol services through the Indian agencies. Telephone services are quite limited throughout our catchment area so we must communicate clearly when we have an opportunity to do so as to where services are available and when they will be available.

Services and Philosophy
We offer a full range of mental health and case management services to adults, children, families, and individuals. These services are available through a number of outreach offices throughout our catchment area and in the homes and other community contact areas, including places of employment, parks, schools, and other facilities.

Employment Services
The direct services provided by Southern Plains Behavioral Health Services include:

- evaluation of employment skills
- education to fill gaps found (budgeting , proper clothing, getting to work on time, proper attitudes and skills)
- transportation to interviews and jobs
- clothing for work interviews
- follow along
- linking to employment agencies
- regular contacts with local employer and employment agencies

Best Practices
Our SPMI program began using the team approach two years before CARE Teams came into existence. Our children's services and SED have been growing each year. We have developed a number of unique services by maintaining the best parts of programs that have come and gone.

Southern Plains Behavioral Health Services was one of the first mental health centers to offer home-based services in South Dakota. We were involved in the Wraparound Program, the rural grants during the late 1980's, flood grants during the 1990's' and Project Heartland. Our Local Interagency Team is extremely strong and quite functional. As each of these programs needs to exist with special projects, we included all of those areas that we felt were the strongest parts of those projects into our SED Program.

We are extremely pleased with the progress we have made. We have written a number of grants in an attempt to obtain an RV so we can take our staff to the smaller rural and reservation communities so there will be a place where people can be seen in comfortable and cool conditions during the summer and warm conditions during the winter. Our use of cell phones has been extremely helpful over the past couple of years, although there are places on the reservation where they do not work.

Unique Challenges
Although the problems that we have are not unique to our catchment area, we nevertheless struggle with a number of problems in the more frontier areas of South Dakota. Transportation is almost nonexistent. Southern Plains has recently been involved with the transportation system in the Winner area in helping them to obtain a new bus so public transportation services could be available here. We try to coordinate rides through the Rosebud Sioux Tribe Transportation program so people can get to certain areas. Our outreach workers try to bring necessary items to people's home when they visit them to aid them with this transportation problem.

There is a lack of communication because of the lack of telephones. It is almost impossible to get in touch with people except through message boards that are available in various small communities. This often hampers certain kinds of services, particularly if they are needed on an emergency basis. Because of the poverty, unemployment, and high alcoholism rates on the reservation, people are already stressed to the maximum and few resources are available because of these problems. Therefore, when something unusual happens, such as a storm, heavy snows, floods, tornadoes, etc., the communities are unable to respond appropriately. It is then necessary for other services to pick up; including those services which are already available in the community through Southern Plains but need to be increased during this particular time.

A large geographic catchment area, limited access to psychiatric services, etc. make it necessary for us to be the passthrough or conduit from treatment services from all of the other psychiatric facilities in Sioux Falls, Rapid City, and Yankton through our local physicians and our part-time psychiatrist. We have been involved with telepsychiatry for

about a year. It has been very helpful. Our nurse spends a great deal of time filling medication bars and delivering them to various parts of the communities.

The Future

Our goals include developing more unique and stable services on the Reservation. The major complaint we have from the reservation is that people and agencies come to the reservation offering various kinds of services and that for a few months or a year everything is supposed to be wonderful and lots of services are promised. However, after a very short time, the services die out or the agency disappears. Southern Plains Mental Health Center has been available on the Reservation for over twenty-five years and we are now seen as the most stable agency in the area. However, we continue to strive toward development and continuation of present programs. These often fluctuate because of funding source problems, but we continue to do whatever we can to stabilize these programs. We make counseling services available on an as-needed, sometimes free, basis in those situations where they are necessary. Our agency and its Board of Directors feels we are part of each community we go into and we do whatever we can to aid that particular community in any individual ongoing community problems.

Three Rivers Mental Health Center, Lemmon, SD

Written by Susan Sangren, Executive Director

Population Challenges
About two thirds of our clients are enrolled members of either the Cheyenne River Nation or the Standing Rock Nation. About one third of the citizens served by Three Rivers Mental Health and Chemical Dependency Center are members of families whose primary income derives from agriculture or livestock production. The entire catchment area is rural and is spread over more than 10,000 square miles. Current caseloads are comprised of about two thirds children. Only about 10 percent of families in our catchment area have private insurance. More than half of adults served by our agency are unemployed, largely due to lack of employment, and lack of economic development in the area. Unemployment rates in three regional counties are estimated at between 70 and 80 percent. More than 50% of the children in those counties live below poverty level. About a fourth of our clients share dwellings with other families due to unavailability of affordable housing. Rates of domestic violence, unemployment, citizens receiving Social Security disability benefits, teenage pregnancy, alcoholism, suicide and alcohol-related developmental disabilities are above national averages. The rate of high school graduation, life expectancy and personal incomes are below average. Inhalant abuse is common in the area and the HIV infection rate has been rising.

Services and Philosophy
We offer a full range of services through our agency. These include:
- Therapy and Counseling for Individuals and Families
- Emergency and Crisis Intervention
- Medication Management
- Home-base therapy
- Employee Assistance Programs
- Trauma counseling
- Social Skills development
- Case Management for children and adults
- Sex Offender Group Treatment

Our agency staff may be considered generalist and eclectic in their approach to human service delivery. Individuals' eligibility for and access to services, target populations – those given priority – include severely emotionally or behaviorally disturbed children and their families, single parents, pregnant women, chronically mentally ill adults and individuals confronting trauma or crises.

None of the programs offered can be categorized as strongest at this point. Perhaps the main achievements are networking with area community clinics, public BIA schools,

Indian Health Service facilities, and state, tribal and BIA social services agencies. Our staff demonstrates good commitment. They work under stressful conditions and oftentimes are isolated. Although they cannot be paid for the many hours spent traveling to conduct outreach each month, they maintain positive attitudes, usually.

Best Practices

Our *Best Practices* may be limited to development of a strong and extensive network with BIA and Public Health Services on two reservations and in two states, with Tribal and Public Schools, and with community health clinics. We are also fairly adept relative to addressing traumatic stress, as we have abundant opportunity to exercise pertinent skills. Most of those accessing our programs are adversely affected by recent and historic trauma.

We are not utilizing innovative technology and are under-accessing technology that would be beneficial in terms of efficacious service delivery. That is because it costs too much. It becomes a vicious circle because that which could reduce costs over the long run costs too much up front.

The Future

We will strive to remain sensitive to behavioral healthcare issues most pertinent to the unique combination of citizens in northwest South Dakota.